HOSPITAL MEDICINES LIST
RESTRICTIONS CHECKLIST

Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to Section H of the Pharmaceutical Schedule. For community funding, see the Special Authority Criteria.

PRESCRIBER

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Finasteride

INITIATION

Prerequisites (tick boxes where appropriate)

- ○ Patient has symptomatic benign prostatic hyperplasia

and

or

- ○ The patient is intolerant of non-selective alpha blockers or these are contraindicated
- ○ Symptoms are not adequately controlled with non-selective alpha blockers

I confirm that the above details are correct:

Signed: ..... Date: .....