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: .....

Ivabradine

INITIATION

Prerequisites (tick boxes where appropriate)

- ○ Patient is indicated for computed tomography coronary angiography

and

- ○ Patient has a heart rate of greater than 70 beats per minute while taking a maximally tolerated dose of beta blocker

or

- ○ Patient is unable to tolerate beta blockers

HOSPITAL

I confirm that the above details are correct:

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