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.

PRESCR	IBER	PATIENT:
Name:		Name:
Ward:		NHI:
Enteral	liqui	id peptide formula
INITIATI Prerequ		(tick boxes where appropriate)
an	O	Patient has impaired gastrointestinal function and either cannot tolerate polymeric feeds, or polymeric feeds are unsuitable
		O Severe malabsorption
	or	O Short bowel syndrome
	or	O Intractable diarrhoea
	or	O Biliary atresia
	or	O Cholestatic liver diseases causing malabsorption
	or	O Cystic fibrosis
	or	O Proven fat malabsorption
	or	O Severe intestinal motility disorders causing significant malabsorption
	or	O Intestinal failure
	or	O The patient is currently receiving funded amino acid formula
		and The patient is to be trialled on, or transitioned to, an enteral liquid peptide formula
an	.d	
an		O A semi-elemental or partially hydrolysed powdered feed has been reasonably trialled and considered unsuitable
	or	O For step down from intravenous nutrition
Note: A	reasoi	nable trial is defined as a 2-4 week trial.
CONTIN		
		(tick boxes where appropriate)
	0	An assessment as to whether the patient can be transitioned to a cows milk protein or soy infant formula or extensively hydrolysed formula has been undertaken
an		The outcome of the assessment is that the patient continues to require an enteral liquid peptide formula