## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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	PATIENT:
Name:	Name:
Ward:	NHI:
Cabergoline	
INITIATION Prerequisites (tick boxes where appropriate)	
O Inhibition of lactation	
O Patient has hyperprolactinemia	
O Patient has acromegaly	
Note: Indication marked with * is an unapproved indication.	

I confirm that the above details are correct:

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