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					PATIENT:	
Name	ə:					Name:
Ward	:					NHI:
Tolvaptan						
INITIATION – autosomal dominant polycystic kidney disease Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a renal physician or any relevant practitioner on the recommendation of a renal physician, or in accordance						
and	and	0	Pat	ient has an estimated glomerular filtration rate (eGF	ant pol	
	and	or	C			n eGFR of greater than or equal to 5 mL/min/1.73 m² within one-year e decline in eGFR of greater than or equal to 2.5 mL/min/1.73 m² per
CONTINUATION – autosomal dominant polycystic kidney disease Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)						
and				d by, or recommended by a renal physician or any rotocol or guideline that has been endorsed by the Ho		at practitioner on the recommendation of a renal physician, or in accordance IZ Hospital.
	and	0		ient has not developed end-stage renal disease, de ient has not undergone a kidney transplant	fined a	us an eGFR of less than 15 mL/min/1.73 m ²

Signed: Date: