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: .....

Bedaquiline

INITIATION – multi-drug resistant tuberculosis
Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)

- ○ The person has multi-drug resistant tuberculosis (MDR-TB)

and

- ○ Ministry of Health's Tuberculosis Clinical Network has reviewed the individual case and recommends bedaquiline as part of the treatment regimen

I confirm that the above details are correct:

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