

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: .....

**Budesonide with glycopyrronium and eformoterol**

**INITIATION**

**Prerequisites** (tick boxes where appropriate)

- ☐ Patient has a diagnosis of COPD confirmed by spirometry or spirometry has been attempted and technically acceptable results are not possible

and

- ☐ Patient is currently receiving an inhaled corticosteroid with long acting beta-2 agonist (ICS/LABA) or a long acting muscarinic antagonist with long acting beta-2 agonist (LAMA/LABA)

and

**Clinical criteria:**

- ☐ Patient has a COPD Assessment Test (CAT) score greater than 10
- or
- ☐ Patient has had 2 or more exacerbations in the previous 12 months
- or
- ☐ Patient has had one exacerbation requiring hospitalisation in the previous 12 months
- or
- ☐ Patient has had an eosinophil count greater than or equal to  $0.3 \times 10^9$  cells/L in the previous 12 months

or

- ☐ Patient is currently receiving multiple inhaler triple therapy (inhaled corticosteroid with long-acting muscarinic antagonist and long-acting beta-2 agonist – ICS/LAMA/LABA) and met at least one of the clinical criteria above prior to commencing multiple inhaler therapy

I confirm that the above details are correct:

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