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: .....

Alpha tocopheryl

INITIATION – Cystic fibrosis

Prerequisites (tick boxes where appropriate)

- ○ Cystic fibrosis patient

and

or

- ○ Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck)
- ○ The other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate for the patient

INITIATION – Osteoradionecrosis

Prerequisites (tick box where appropriate)

- ○ For the treatment of osteoradionecrosis

INITIATION – Other indications

Prerequisites (tick boxes where appropriate)

- ○ Infant or child with liver disease or short gut syndrome

and

- ○ Requires vitamin supplementation

and

or

- ○ Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplements (Vitabdeck)
- ○ The other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate for patient

I confirm that the above details are correct:

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