

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:

Eplerenone

INITIATION

Prerequisites (tick boxes where appropriate)

☐ Patient has heart failure with ejection fraction less than 40%
and

☐ Patient is intolerant to optimal dosing of spironolactone

or
☐ Patient has experienced a clinically significant adverse effect while on optimal dosing of spironolactone

I confirm that the above details are correct:

Signed: Date: