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: .....

Enteral liquid peptide formula

INITIATION

Prerequisites (tick boxes where appropriate)

- ○ Patient has impaired gastrointestinal function and either cannot tolerate polymeric feeds, or polymeric feeds are unsuitable

and

- ○ Severe malabsorption

or

- ○ Short bowel syndrome

or

- ○ Intractable diarrhoea

or

- ○ Biliary atresia

or

- ○ Cholestatic liver diseases causing malabsorption

or

- ○ Cystic fibrosis

or

- ○ Proven fat malabsorption

or

- ○ Severe intestinal motility disorders causing significant malabsorption

or

- ○ Intestinal failure

or

  - ○ The patient is currently receiving funded amino acid formula

  and

  - ○ The patient is to be trialled on, or transitioned to, an enteral liquid peptide formula

and

- ○ A semi-elemental or partially hydrolysed powdered feed has been reasonably trialled and considered unsuitable

or

- ○ For step down from intravenous nutrition

Note: A reasonable trial is defined as a 2-4 week trial.

CONTINUATION

Prerequisites (tick boxes where appropriate)

- ○ An assessment as to whether the patient can be transitioned to a cows milk protein or soy infant formula or extensively hydrolysed formula has been undertaken

and

- ○ The outcome of the assessment is that the patient continues to require an enteral liquid peptide formula

I confirm that the above details are correct:

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

HOSPITAL