HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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	PATIENT:
Name:	Name:
Ward:	NHI:
L-ornithine L-aspartate	
INITIATION	
Prerequisites (tick box where appropriate)	
O For patients with chronic hepatic encephalopathy who have not responded to treatment with, or are intolerant to lactulose, or where lactulose is contraindicated	