

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: .....

**Multivitamin renal**

**INITIATION**

**Prerequisites** (tick boxes where appropriate)

- ☐ The patient has chronic kidney disease and is receiving either peritoneal dialysis or haemodialysis
- or
- ☐ The patient has chronic kidney disease grade 5, defined as patient with an estimated glomerular filtration rate of < 15 ml/min/1.73m<sup>2</sup> body surface area (BSA)

I confirm that the above details are correct:

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