

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:

Clarithromycin

INITIATION – Tab 250 mg and oral liquid

Prerequisites (tick boxes where appropriate)

- ☐ Atypical mycobacterial infection
or
☐ Mycobacterium tuberculosis infection where there is drug resistance or intolerance to standard pharmaceutical agents
or
☐ Helicobacter pylori eradication
or
☐ Prophylaxis of infective endocarditis associated with surgical or dental procedures if amoxicillin is contra-indicated

INITIATION – Tab 500 mg

Prerequisites (tick box where appropriate)

- ☐ Helicobacter pylori eradication

INITIATION – Infusion

Prerequisites (tick boxes where appropriate)

- ☐ Atypical mycobacterial infection
or
☐ Mycobacterium tuberculosis infection where there is drug resistance or intolerance to standard pharmaceutical agents
or
☐ Community-acquired pneumonia

I confirm that the above details are correct:

Signed: Date: