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:
Eptifibatide				
INITIATION Prerequisites (tick boxes where appropriate)				
		0	O For use in patients with acute coronary syndromes undergoing percutaneous coronary intervention	
	or	0	For use in patients with definite or strongly suspected intra-coronary thrombus on coronary angiography	
	or	0	For use in patients undergoing intra-cranial intervention	