

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

- ☐ 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: