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:
Tolvaptan	
INITIATION – autosomal dominant polycystic kidney disease Re-assessment required after 12 months	
Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a renal physician or any relevan with a protocol or guideline that has been endorsed by the Health N	t practitioner on the recommendation of a renal physician, or in accordance Z Hospital.
Patient has a confirmed diagnosis of autosomal dominant poly	/cystic kidney disease
O Patient has an estimated glomerular filtration rate (eGFR) of g	reater than or equal to 25 ml/min/1.73 m ² at treatment initiation
	n eGFR of greater than or equal to 5 mL/min/1.73 m² within one-year
O Patient's disease is rapidly progressing, with an average year over a five-year period	e decline in eGFR of greater than or equal to 2.5 mL/min/1.73 m² per
CONTINUATION – autosomal dominant polycystic kidney disease Re-assessment required after 12 months	
Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a renal physician or any relevan with a protocol or guideline that has been endorsed by the Health N	t practitioner on the recommendation of a renal physician, or in accordance Z Hospital.
Patient has not developed end-stage renal disease, defined a	s an eGFR of less than 15 mL/min/1.73 m ²
Patient has not undergone a kidney transplant	

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Signed.	Date:	
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