

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: NHI:

Diazoxide

INITIATION

Prerequisites (tick box where appropriate)

For patients with confirmed hypoglycaemia caused by hyperinsulinism

PATIENT:

Name:

I confirm that the above details are correct:

Signed: Date: