

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:

L-ornithine L-aspartate**INITIATION****Prerequisites** (tick box where appropriate)

For patients with chronic hepatic encephalopathy who have not responded to treatment with, or are intolerant to lactulose, or where lactulose is contraindicated

I confirm that the above details are correct:

Signed: Date: