

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:

Ivabradine

INITIATION

Prerequisites (tick boxes where appropriate)

and

Patient is indicated for computed tomography coronary angiography

or

Patient has a heart rate of greater than 70 beats per minute while taking a maximally tolerated dose of beta blocker

Patient is unable to tolerate beta blockers

I confirm that the above details are correct:

Signed: Date: