

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:

Cabergoline

INITIATION

Prerequisites (tick boxes where appropriate)

or

- Inhibition of lactation
- Patient has hyperprolactinemia
- Patient has acromegaly

Note: Indication marked with * is an unapproved indication.

I confirm that the above details are correct:

Signed: Date: