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: ....

PATIENT:

Name: ....

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: ....