

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: .....

**Eptifibatide**

**INITIATION**

**Prerequisites** (tick boxes where appropriate)

- For use in patients with acute coronary syndromes undergoing percutaneous coronary intervention

or

- For use in patients with definite or strongly suspected intra-coronary thrombus on coronary angiography

or

- For use in patients undergoing intra-cranial intervention

HOSPITAL

I confirm that the above details are correct:

Signed: ..... Date: .....