

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**

**PATIENT:**

Name: .....

Name: .....

Ward: .....

NHI: .....

**Enteral liquid peptide formula**

**INITIATION**

**Prerequisites** (tick boxes where appropriate)

Patient has impaired gastrointestinal function and either cannot tolerate polymeric feeds, or polymeric feeds are unsuitable  
**and**

- Severe malabsorption
- or**
- Short bowel syndrome
- or**
- Intractable diarrhoea
- or**
- Biliary atresia
- or**
- Cholestatic liver diseases causing malabsorption
- or**
- Cystic fibrosis
- or**
- Proven fat malabsorption
- or**
- Severe intestinal motility disorders causing significant malabsorption
- or**
- Intestinal failure

- The patient is currently receiving funded amino acid formula  
**and**
- The patient is to be trialled on, or transitioned to, an enteral liquid peptide formula

- and**
- A semi-elemental or partially hydrolysed powdered feed has been reasonably trialled and considered unsuitable
  - or**
  - For step down from intravenous nutrition

Note: A reasonable trial is defined as a 2-4 week trial.

**CONTINUATION**

**Prerequisites** (tick boxes where appropriate)

- An assessment as to whether the patient can be transitioned to a cows milk protein or soy infant formula or extensively hydrolysed formula has been undertaken  
**and**
- The outcome of the assessment is that the patient continues to require an enteral liquid peptide formula

I confirm that the above details are correct:

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