HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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: ....

Finasteride

INITIATION

Prerequisites (tick boxes where appropriate)

- ◯ Patient has symptomatic benign prostatic hyperplasia

and

- ◯ The patient is intolerant of non-selective alpha blockers or these are contraindicated

  or

- ◯ Symptoms are not adequately controlled with non-selective alpha blockers

I confirm that the above details are correct:

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