

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:

Liothyronine sodium - Tab 20 mcg

INITIATION

Prerequisites (tick box where appropriate)

- For a maximum of 14 days' treatment in patients with thyroid cancer who are due to receive radioiodine therapy

HOSPITAL

I confirm that the above details are correct:

Signed: Date: