

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:

Pimecrolimus

INITIATION

Prerequisites (tick boxes where appropriate)

☐ Prescribed by, or recommended by a dermatologist, paediatrician or ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ☐ Patient has atopic dermatitis on the eyelid
- and
- ☐ Patient has at least one of the following contraindications to topical corticosteroids: periorificial dermatitis, rosacea, documented epidermal atrophy, documented allergy to topical corticosteroids, cataracts, glaucoma, or raised intraocular pressure

I confirm that the above details are correct:

Signed: Date: