

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: .....

**Alpha tocopheryl**

**INITIATION – Cystic fibrosis**

**Prerequisites** (tick boxes where appropriate)

☐ Cystic fibrosis patient  
and

☐ Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck)

or  
☐ The other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate for the patient

**INITIATION – Osteoradionecrosis**

**Prerequisites** (tick box where appropriate)

☐ For the treatment of osteoradionecrosis

**INITIATION – Other indications**

**Prerequisites** (tick boxes where appropriate)

☐ Infant or child with liver disease or short gut syndrome  
and

☐ Requires vitamin supplementation  
and

☐ Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplements (Vitabdeck)

or  
☐ The other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate for patient

I confirm that the above details are correct:

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