

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: .....

**Long-acting muscarinic antagonists with long-acting beta-adrenoceptor agonists**

**INITIATION**

Re-assessment required after 2 years

**Prerequisites** (tick boxes where appropriate)

- Patient has been stabilised on a long acting muscarinic antagonist  
**and**  
 The prescriber considers that the patient would receive additional benefit from switching to a combination product

**CONTINUATION**

Re-assessment required after 2 years

**Prerequisites** (tick boxes where appropriate)

- Patient is compliant with the medication  
**and**  
 Patient has experienced improved COPD symptom control (prescriber determined)

I confirm that the above details are correct:

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