

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:

Methylnaltrexone bromide

INITIATION – Opioid induced constipation

Prerequisites (tick boxes where appropriate)

The patient is receiving palliative care

and

Oral and rectal treatments for opioid induced constipation are ineffective

or

Oral and rectal treatments for opioid induced constipation are unable to be tolerated

I confirm that the above details are correct:

Signed: Date: