

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

**INITIATION – Opioid induced constipation outside of palliative care**

Re-assessment required after 14 days

Prerequisites (tick boxes where appropriate)

Individual has opioid induced constipation

and

Oral and rectal treatments for opioid induced constipation, including bowel-cleansing preparations, are ineffective or inappropriate

and

Mechanical bowel obstruction has been excluded

I confirm that the above details are correct:

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