

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:

Buprenorphine with naloxone

INITIATION – Detoxification

Prerequisites (tick boxes where appropriate)

- ☐ Patient is opioid dependent
and
☐ Patient is currently engaged with an opioid treatment service approved by the Ministry of Health
and
☐ Prescriber works in an opioid treatment service approved by the Ministry of Health

INITIATION – Maintenance treatment

Prerequisites (tick boxes where appropriate)

- ☐ Patient is opioid dependent
and
☐ Patient will not be receiving methadone
and
☐ Patient is currently enrolled in an opioid substitution treatment program in a service approved by the Ministry of Health
and
☐ Prescriber works in an opioid treatment service approved by the Ministry of Health

I confirm that the above details are correct:

Signed: Date: