HOSPITAL MEDICINES LIST
RESTRICTIONS CHECKLIST

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: .....