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		PATIENT:
Name:		Name:
Ward:		NHI:
Varenicline		
INITIATION Prerequisites (ti	ick boxes where appropriate)	
and T	Short-term therapy as an aid to achieving abstinence in a patie.  The patient is part of, or is about to enrol in, a comprehensive prescriber or nurse monitoring.	ent who has indicated that they are ready to cease smoking support and counselling smoking cessation programme, which includes
The patient has tried but failed to quit smoking after at least two separate trials of nicotine replacement therapy, at least which included the patient receiving comprehensive advice on the optimal use of nicotine replacement therapy  The patient has tried but failed to quit smoking using bupropion or nortriptyline		
and O v	The patient has not had a Special Authority for varenicline applarenicline is not to be used in combination with other pharmatics	cological smoking cessation treatments and the patient has agreed to
and	The patient is not pregnant The patient will not be prescribed more than 12 weeks' funded	varenicline in a 12 month period

I confirm that the above details are correct:

C:	D-1	
Signed.	Date:	
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