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: .....

Naltrexone hydrochloride

INITIATION – Alcohol dependence

Prerequisites (tick boxes where appropriate)

- ○ Patient is currently enrolled, or is planned to be enrolled, in a recognised comprehensive treatment programme for alcohol dependence

and

- ○ Naltrexone is to be prescribed by, or on the recommendation of, a physician working in an Alcohol and Drug Service

INITIATION – Constipation

Prerequisites (tick box where appropriate)

- ○ For the treatment of opioid-induced constipation

I confirm that the above details are correct:

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