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.

PRESC	CRIE	BER		PATIENT:				
Name:				Name:				
Ward:				NHI:				
Varenicline								
INITIA Prerec			(tick boxes where appropriate)					
	and	0	Short-term therapy as an aid to achieving abstinence in a patie	ent who has indicated that they are ready to cease smoking				
	and	0	The patient is part of, or is about to enrol in, a comprehensive prescriber or nurse monitoring	support and counselling smoking cessation programme, which includes				
		or	 The patient has tried but failed to quit smoking after at lead which included the patient receiving comprehensive advectors. The patient has tried but failed to quit smoking using but 					
	and and	0	The patient has not had a Special Authority for varenicline app	proved in the last 6 months				
		\bigcirc	Varenicline is not to be used in combination with other pharmathis	acological smoking cessation treatments and the patient has agreed to				
	and and	0	The patient is not pregnant					
	anu	\circ	The patient will not be prescribed more than 12 weeks' funded	I varenicline in a 12 month period				

I confirm that the above details are correct:

C:	D-1	
Signed.	Date:	
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