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:	
Paliperidone palmitate		
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) The patient has schizophrenia and The patient has had an initial Special Authority approval for patients.	aliperidone once-monthly depot injection	
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate) The initiation of paliperidone depot injection has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of an atypical antipsychotic depot injection		

I confirm that the above details are correct:

0:	D - 1 - 1	
Zigneg.	i jate:	
Oigilica.	 Duic.	