## 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   | PATIENT:              |
|--|-----------------------|
| Name:  | Name:                 |
| Ward:  | NHI:                  |
| Buprenorphine with naloxone  |                       |
| INITIATION – Detoxification   Prerequisites (tick boxes where appropriate)   O Patient is opioid dependent   and O   Patient is currently engaged with an opioid treatment service approved by the Ministry of Health   O Prescriber works in an opioid treatment service approved by the Ministry of Health |                       |
| INITIATION – Maintenance treatment   Prerequisites (tick boxes where appropriate)   O Patient is opioid dependent   and O   Patient will not be receiving methadone   and O   Patient is currently enrolled in an opioid substitution treatment program in a service approved by the Ministry of Health      |                       |
| And O Prescriber works in an opioid treatment service approved by t  | he Ministry of Health |

Page 1

I confirm that the above details are correct: