## 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.

PRESC	RIBER	PATIENT:
Name:		Name:
Ward:		NHI:

## Paliperidone

INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)					
	or	0		patient has had an initial Special Authority approval for risperidone depot injection or olanzapine depot injection or aripiprazole of injection	
		an	O d	The patient has schizophrenia or other psychotic disorder	
		an	d d	The patient has been unable to adhere to treatment using oral atypical antipsychotic agents	
			0	The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in the last 12 months	

## 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  $\bigcirc$ 

I confirm that the above details are correct:

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