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) Patient is opioid dependent and Patient is currently engaged with an opioid treatment service and Prescriber works in an opioid treatment service approved by the		
INITIATION – Maintenance treatment Prerequisites (tick boxes where appropriate)		
Patient is opioid dependent and Patient will not be receiving methadone and Patient is currently enrolled in an opioid substitution treatment and Prescriber works in an opioid treatment service approved by the		

C:	D-1	
Signed.	Date:	
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