

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

Name:

Ward:

PATIENT:

Name:

NHI:

Methylnaltrexone bromide

INITIATION – Opioid induced constipation

Prerequisites (tick boxes where appropriate)

The patient is receiving palliative care
and

Oral and rectal treatments for opioid induced constipation are ineffective

or
 Oral and rectal treatments for opioid induced constipation are unable to be tolerated

INITIATION – Opioid induced constipation outside of palliative care

Re-assessment required after 14 days

Prerequisites (tick boxes where appropriate)

Individual has opioid induced constipation
and

Oral and rectal treatments for opioid induced constipation, including bowel-cleansing preparations, are ineffective or inappropriate
and

Mechanical bowel obstruction has been excluded

I confirm that the above details are correct:

Signed: Date: