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

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Paliperidone

INITIATION
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

- ○ The patient has had an initial Special Authority approval for risperidone depot injection or olanzapine depot injection or aripiprazole depot injection

or

- ○ The patient has schizophrenia or other psychotic disorder

and

- ○ The patient has been unable to adhere to treatment using oral atypical antipsychotic agents

and

- ○ 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

I confirm that the above details are correct:

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