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: .....

Buprenorphine with naloxone

INITIATION – Detoxification

Prerequisites (tick boxes where appropriate)

- ○ Patient is opioid dependent

and

- ○ Patient is currently engaged with an opioid treatment service approved by the Ministry of Health

and

- ○ Prescriber works in an opioid treatment service approved by the Ministry of Health

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 program in a service approved by the Ministry of Health

and

- ○ Prescriber works in an opioid treatment service approved by the Ministry of Health

I confirm that the above details are correct:

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