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 palmitate

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

- ○ The patient has schizophrenia

and

- ○ The patient has had an initial Special Authority approval for paliperidone once-monthly depot injection

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: .....