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: .....

Varenicline

INITIATION

Prerequisites (tick boxes where appropriate)

- ❍ Short-term therapy as an aid to achieving abstinence in a patient who has indicated that they are ready to cease smoking

and

- ❍ The patient is part of, or is about to enrol in, a comprehensive support and counselling smoking cessation programme, which includes prescriber or nurse monitoring

and

- ❍ The patient has tried but failed to quit smoking after at least two separate trials of nicotine replacement therapy, at least one of which included the patient receiving comprehensive advice on the optimal use of nicotine replacement therapy

or

- ❍ The patient has tried but failed to quit smoking using bupropion or nortriptyline

and

- ❍ The patient has not had a Special Authority for varenicline approved in the last 6 months

and

- ❍ Varenicline is not to be used in combination with other pharmacological smoking cessation treatments and the patient has agreed to this

and

- ❍ The patient is not pregnant

and

- ❍ The patient will not be prescribed more than 12 weeks' funded varenicline in a 12 month period

I confirm that the above details are correct:

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