

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: .....

**Risperidone**

**INITIATION**

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

- ☐ The patient has had an initial Special Authority approval for paliperidone depot injection or olanzapine depot injection or aripiprazole depot injection
- or
- ☐ The patient has schizophrenia or other psychotic disorder
- and
- ☐ The patient has not been able 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 risperidone 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: .....