## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Use this checklist to determine if a patient meets the restrictions for funding in the Schedule. For community funding, see the Special Authority Criteria.	ne <b>hospital setting</b> . For more details, refer to Section H of the Pharmaceutical
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	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 patients.	aliperidone 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 wire corresponding period of time prior to the initiation of an atypical antip	th fewer days of intensive intervention than was the case during a osychotic depot injection

I confirm that the above details are correct:

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