

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:

Long-acting muscarinic antagonists with long-acting beta-adrenoceptor agonists

INITIATION

Re-assessment required after 2 years

Prerequisites (tick boxes where appropriate)

- and**
- ☐ Patient has been stabilised on a long acting muscarinic antagonist
 - ☐ The prescriber considers that the patient would receive additional benefit from switching to a combination product

CONTINUATION

Re-assessment required after 2 years

Prerequisites (tick boxes where appropriate)

- and**
- ☐ Patient is compliant with the medication
 - ☐ Patient has experienced improved COPD symptom control (prescriber determined)

I confirm that the above details are correct:

Signed: Date: