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.

PRESCRI	BER	PATIENT:		
Name:		Name:		
Ward:		NHI:		
Buprend	orphine with naloxone			
INITIATIO	N – Detoxification			
Prerequi	sites (tick boxes where appropriate)			
and	Patient is opioid dependent Patient is currently engaged with an opioid treatment service approved by the Ministry of Health Prescriber works in an opioid treatment service approved by the Ministry of Health			
INITIATION – Maintenance treatment Prerequisites (tick boxes where appropriate)				
and and	Patient will not be receiving methadone Patient is currently enrolled in an opioid substitution treatment			

C:	D-1	
Signed.	Date:	
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