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				PATIENT:			
Name	:			Name:			
Ward:				NHI:			
Meth	ylna	ltre	xone bromide				
			Opioid induced constipation (tick boxes where appropriate)				
	and	C	The patient is receiving palliative care				
		or	Oral and rectal treatments for opioid induced constipation are ineffective Oral and rectal treatments for opioid induced constipation are unable to be tolerated				
INITIATION – Opioid induced constipation outside of palliative care Re-assessment required after 14 days Prerequisites (tick boxes where appropriate)							
	and O	C	Individual has opioid induced constipation				
		C	Oral and rectal treatments for opioid induced constipation, incl	uding bowel-cleansing preparations, are ineffective or inappropriate			
)	Mechanical bowel obstruction has been excluded				

I confirm that the above details are correct:

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