

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:

Naltrexone hydrochloride

INITIATION – Alcohol dependence

Prerequisites (tick boxes where appropriate)

- ☐ Patient is currently enrolled, or is planned to be enrolled, in a recognised comprehensive treatment programme for alcohol dependence
and
☐ Naltrexone is to be prescribed by, or on the recommendation of, a physician working in an Alcohol and Drug Service

INITIATION – Constipation

Prerequisites (tick box where appropriate)

- ☐ For the treatment of opioid-induced constipation

I confirm that the above details are correct:

Signed: Date: