

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: .....

**Methylnaltrexone bromide**

**INITIATION – Opioid induced constipation**

**Prerequisites** (tick boxes where appropriate)

☐ The patient is receiving palliative care  
**and**

☐ Oral and rectal treatments for opioid induced constipation are ineffective

**or**  
☐ 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)

☐ Individual has opioid induced constipation  
**and**

☐ Oral and rectal treatments for opioid induced constipation, including bowel-cleansing preparations, are ineffective or inappropriate  
**and**

☐ Mechanical bowel obstruction has been excluded

I confirm that the above details are correct:

Signed: ..... Date: .....