

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: ..... NHI: .....

**MethylNaltrexone bromide**

**INITIATION – Opioid induced constipation**

**Prerequisites** (tick boxes where appropriate)

and  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  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: .....