

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:

Long-Acting Muscarinic Antagonists with Long-Acting Beta-Adrenoceptor Agonists

INITIATION

Prerequisites (tick boxes where appropriate)

- ☐ Patient has been stabilised on a long acting muscarinic antagonist
and ☐ The prescriber considers that the patient would receive additional benefit from switching to a combination product

I confirm that the above details are correct:

Signed: Date: