

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: .....

**Buprenorphine with naloxone**

**INITIATION – Detoxification**

**Prerequisites** (tick boxes where appropriate)

- Patient is opioid dependent
- and  Patient is currently engaged with an opioid treatment service approved by the Ministry of Health
- and  Prescriber works in an opioid treatment service approved by the Ministry of Health

**INITIATION – Maintenance treatment**

**Prerequisites** (tick boxes where appropriate)

- Patient is opioid dependent
- and  Patient will not be receiving methadone
- and  Patient is currently enrolled in an opioid substitution treatment program in a service approved by the Ministry of Health
- and  Prescriber works in an opioid treatment service approved by the Ministry of Health

I confirm that the above details are correct:

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