

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: .....