

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**

**PATIENT:**

Name: .....

Ward: ..... 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: .....