

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:

Paliperidone palmitate

INITIATION

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

- The patient has schizophrenia
and
 The patient has had an initial Special Authority approval for paliperidone once-monthly depot injection

CONTINUATION

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

- The initiation of paliperidone depot injection has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of an atypical antipsychotic depot injection

I confirm that the above details are correct:

Signed: Date: