

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**

**INITIATION**

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

The patient has had an initial Special Authority approval for risperidone depot injection or olanzapine depot injection or aripiprazole depot injection

or

The patient has schizophrenia or other psychotic disorder

and

The patient has been unable to adhere to treatment using oral atypical antipsychotic agents

and

The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in the last 12 months

**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: .....