Eligibility Assessment | FDA-Approved Opioid Antagonist

for reversal of opioid-related overdose

ASSESSMENT CRITERIA	YES	NO
Individual is: 1) a person at risk of an opioid-related overdose, or 2) a family member, friend, or close third party to a person at risk of experiencing an opioid-related overdose.		
Person at risk does NOT have a known allergy or sensitivity to an opioid antagonist or any component of the product to be dispensed (answer "yes" if there is no known allergy or the person at risk is not known to the individual).		
Individual is oriented to person, place and time and understands the essential components of opioid-related overdose, appropriate response, and opioid antagonist administration.		

PREVIOUS PRESCRIPTION INFORMATION	
If recipient has received an opioid antagonist previously, the last dispensed product was:	CHECK
1. Administered to reverse potential opioid-related overdose	
2. Lost	
3. Stolen or confiscated	
4. Destroyed or expired	

By my initials below, I acknowledge:

1. I have been provided with information and understand the essential components of opioid-related overdose, appropriate response, medication storage conditions, and medication administration.
2. I attest that I will provide opioid-related overdose, appropriate response, and medication storage and administration information to any other person in a position to assist who may use the medication.
3. I understand that no further distribution of this product is allowed, unless in an emergency overdose situation.
4. I understand that administering an opioid antagonist is not a substitute for professional medical evaluation.

_____ _____

(Eligible recipient / patient initials) **Date**

To be completed by the pharmacist:

	YES	NO
Individual is determined to be ELIGIBLE to receive an opioid antagonist at this time		
Individual has insurance, Medicaid or other 3rd party payer source/ the ability to pay (if no, continue to next line)		
Individual does not have the ability to pay either due to no insurance/3rd party payer source or they are experiencing financial circumstances that impacts the ability to pay.		

By my signature below, I attest that I have, in good faith, provided the required training and education to the eligible recipient identified above:

_____ Date: _____ SD **PHARMACY** License # 100-_____

(Authorized R.Ph./Intern signature) (NOT Pharmacist license #)

Product dispensed: _____ Quantity dispensed: _____

Assessment form must be maintained with pharmacy records for at least two years. Quarterly reports for all FDA-approved opioid antagonists dispensed through the statewide standing order must be submitted per the guidelines outlined within the standing order. Report submission can be completed at: https://letsbeclearsd.com/providers/pharmacy/naloxone-quarterly-report