

## Eligibility Assessment to receive naloxone for reversal of opioid-related overdose

<b>ASSESSMENT CRITERIA</b>	<b>YES</b>	<b>NO</b>
Individual is: 1) a person at risk, 2) a family member or friend of person at risk, 3) a person in a position to assist a person at risk, 4) a first responder	<input type="checkbox"/>	<input type="checkbox"/>
Person at risk does NOT have a known allergy or sensitivity to naloxone 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)	<input type="checkbox"/>	<input type="checkbox"/>
Individual is oriented to person, place and time and understands the essential components of opioid-related overdose, appropriate response, and naloxone administration.	<input type="checkbox"/>	<input type="checkbox"/>
Individual is determined to be ELIGIBLE to receive naloxone at this time (complete absence of "no" responses to above criteria)**	<input type="checkbox"/>	<input type="checkbox"/>

\*\*Even if individual is NOT eligible to receive naloxone at this time, this assessment form must be maintained with pharmacy records for at least two years, be available for inspection and copying by the board or its authorized agent, and must be submitted to the Iowa Department of Public Health.

<b>PREVIOUS PRESCRIPTION INFORMATION</b>	
If recipient has received naloxone previously, the last dispensed product was:	<b>CHECK</b>
1. Administered to reverse an opioid-related overdose	<input type="checkbox"/>
2. Lost	<input type="checkbox"/>
3. Stolen or confiscated	<input type="checkbox"/>
4. Destroyed or expired	<input type="checkbox"/>

By my initials below, I acknowledge:

1. I have been provided with information and understand the essential components of opioid-related overdose, appropriate response, naloxone storage conditions, and naloxone administration.
2. I attest that I will provide opioid-related overdose, appropriate response, and naloxone 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.

\_\_\_\_\_  
(Eligible recipient initials)

\_\_\_\_\_  
Date

If eligible recipient is purchasing on behalf of an agency or harm reduction organization, the name of the agency or harm reduction organization: \_\_\_\_\_

Below to be completed by the authorized pharmacist:

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

\_\_\_\_\_  
(Authorized RPh/Intern signature)      Date: \_\_\_\_\_      IA Pharmacy License No./County: \_\_\_\_\_ / \_\_\_\_\_

Product dispensed: \_\_\_\_\_ Qty of kits dispensed: \_\_\_\_\_

Medical director under whose authority granted this prescription: \_\_\_\_\_

Individual is eligible, but did not receive naloxone (provide reason) _____
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**Submit this assessment form to Iowa Department of Public Health via fax to 515-725-4098 within seven (7) days of dispensing or denied eligibility.**