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

ASSESSMENT CRITERIA	YES	NO
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		
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)		
Individual is oriented to person, place and time and understands the essential components of opioid-related overdose, appropriate response, and naloxone administration.		
Individual is determined to be ELIGIBLE to receive naloxone at this time (complete absence of "no" responses to above criteria)**		

**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 Health and Human Services.

PREVIOUS PRESCRIPTION INFORMATION	
If recipient has received naloxone previously, the last dispensed product was:	**CHECK**
1. Administered to reverse an 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, 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:

_____ Date: _____ IA **PHARMACY** License No./County: _____/_____

(Authorized RPh/Intern signature) **(NOT Pharmacist license)**

Product dispensed: _____ Qty of kits dispensed: _____

Medical director under whose authority granted this prescription: _____

Individual is eligible, but did not receive naloxone (provide reason) _____

Submit this assessment form to Iowa Department of Health and Human Services via fax to 515-725-4098 within seven (7) days of dispensing or denied eligibility.