



Eligibility Assessment | Naloxone

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 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.		

PREVIOUS PRESCRIPTION INFORMATION	CHECK
If recipient has received naloxone previously, the last dispensed product was:	
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, 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, unless in an emergency overdose situation.
4. I understand that administering naloxone 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 naloxone at this time		
Individual has insurance, Medicaid or other 3 rd 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/3 rd 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:

(Authorized R.Ph./Intern signature) Date: _____ SD **PHARMACY** License # 100-
(NOT Pharmacist license #)

Product dispensed: _____ Quantity dispensed: _____

Assessment form must be maintained with pharmacy records for at least two years. Quarterly reports for all naloxone dispensed through the statewide standing order must be submitted per the guidelines outlined within the standing order. Report submission can be completed at: www.avoidopioidsd.com/pharmacy/quarterly-reports