New Zealand Government
Te Kāwanatanga o Aotearoa

MINISTRY OF HEALTH
MANATŪ HAUORA

Consultation on Developing a Specified Prescription Medicines List for Designated Paramedic Prescribers

Released 2026

Acknowledgements

The Ministry of Health engaged with several key stakeholders when developing this consultation in partnership with Te Kaunihera Manapou – the Paramedic Council of New Zealand.

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Purpose

The Ministry of Health – Manatū Hauora (the Ministry) invites submissions on a proposed specified prescription medicines list (SPML) for designated paramedic prescribers (paramedic prescribers).

The Ministry, on behalf of the Director-General of Health, must consult with those people or organisations that may be affected by the development of a SPML before making a legal change by Gazette notice.

This consultation enables you to provide feedback on the proposed medicines, or to propose medicines that have not been referenced.

- **View the proposed medicines list (Appendix 1)**

Please submit your feedback on the proposed amendments by **5 July 2026**.

Background

Aotearoa New Zealand's health system is experiencing sustained increases in demand for urgent and primary care services, alongside significant workforce pressures and persistent inequities in access to timely treatment. These challenges disproportionately affect Māori, Pacific peoples, and communities in rural and remote areas.

Paramedics are a regulated health profession who already provide assessment, treatment, and medicine administration across emergency, urgent, primary, and community settings. However, paramedics currently do not have prescribing authority and instead rely on standing orders issued by authorised prescribers.[1] The standing order framework was not designed to support contemporary models of mobile, community-based care and can result in administrative burden, fragmented accountability, inconsistent access to medicines, and delays in treatment for patients.

Paramedic prescribing authority

Te Kaunihera Manapou – the Paramedic Council of New Zealand (Te Kaunihera) is the responsible authority for paramedics under the Health Practitioners Competence Assurance Act 2003 (HPCA Act).

Te Kaunihera undertook a public consultation in late 2025 to assess whether paramedics in New Zealand should be granted prescribing authority, and under what conditions. An independent analysis of the consultation feedback consultation is available on the **Te Kaunihera website**.

Te Kaunihera has applied to the Ministry for designated prescribing authority[2] for paramedics under the Medicines Act 1981. The prescribing authority application can be found on the **Te Kaunihera website**.

Designated prescribing authority is the same legal framework used by several non-medical prescribers, such as dietitian prescribers, registered nurse prescribers, pharmacist prescribers, and podiatrist prescribers. This system provides a balanced and recognised way for limited prescribing within clearly defined practice areas.

The Ministry is consulting on the proposed SPML that paramedic prescribers will be able to prescribe in the future once all the appropriate legal steps and specified preparation for prescribing have been put in place by Te Kaunihera.

The Ministry is consulting on the SPML now to enable education and training providers to develop paramedic prescribing courses.

[1] Standing orders are issued pursuant to the Medicines (Standing Order) Regulations 2002.

[2] A designated prescriber is defined as an authorised prescriber who is allowed only to prescribe specified prescription medicines, subject to any conditions stated in the authorised prescriber's scope of practice (Medicines Regulations 1984, Reg 39).

Safety and regulatory safeguards

Public safety underpins the proposal for paramedic prescribing. Safeguards include:

- approved postgraduate prescribing education and competence assessment
- a defined prescribing scope of practice
- a specified list of prescription medicines
- prescribing practice supervision requirements
- ongoing continuing professional development, audit, and review of these requirements
- employer clinical governance safeguards, and
- existing HPCA Act fitness-to-practise, competence, and conduct mechanisms.

International experience with non-medical prescribing demonstrates safe and effective implementation when supported by robust education, regulation, and governance.

Benefits and strategic alignment

The introduction of designated prescribing authority for paramedics is expected to deliver clear benefits for patients and whānau, the health system, and the health workforce, while maintaining public safety and confidence.

Patient and whānau outcomes

Paramedics frequently deliver care in settings where access to prescribers is not immediately available. In rural, remote, and underserved high deprivation communities, this can result in delayed treatment, disrupted continuity of care, repeat presentations, unnecessary referrals, or avoidable hospital admissions.

Paramedic prescribing will enable paramedics to provide more complete care at the point of contact, allowing people to be assessed, treated, and prescribed for in a single episode of care. This reduces delays in treatment, avoids unnecessary repeat referrals, improves continuity of care and the overall patient experience, particularly for people receiving care in their homes, aged residential care, or in communities with limited access to traditional primary care services.

Paramedic prescribers will refer patients to other prescribers for further assessment and treatment when clinically indicated. For instance, should a patient's condition fall beyond the paramedic prescriber's scope of practice, the individual may be referred to a general practitioner, nurse practitioner, or another appropriate healthcare provider.

Paramedic prescribing supports equitable access to healthcare services and strengthens the health system's ability to deliver care closer to home. This is particularly so for communities experiencing worsening structural barriers such as increasing financial impoverishment and geographic barriers to access.

Health system efficiency

Designated prescribing supports more efficient use of the health system's resources by reducing duplication of clinical assessments, and administrative processes associated with standing orders.

In practice, this may contribute to:

- reduced avoidable emergency department presentations
- fewer unnecessary referrals and admissions
- streamlined transitions of care, and
- reduced administrative burden associated with standing orders.

Workforce sustainability and capability

Enabling paramedic prescribing recognises advanced clinical capability, supports professional development pathways, and contributes to workforce sustainability and retention.

Paramedic prescribing will complement multidisciplinary team practice. It does not replace, but rather complements, the roles of experienced health practitioners such as doctors, registered nurses, nurse practitioners, or pharmacists.

Strategic alignment

Paramedic prescribing aligns with the Government's and Health New Zealand's priorities to:

- reduce pressure on emergency and hospital services
- improve access to timely, patient-centred care
- strengthen community-based and integrated models of care
- optimise the use of the regulated health workforce.

Development of the specified medicines list

Paramedics currently use medicines across a wide range of therapeutic groups and clinical settings under standing orders as part of their established practice.

Paramedics without prescribing authority would continue to practise under standing orders.

The proposed SPML (**Appendix 1**) has been informed by medicines currently included in the **New Zealand Emergency Ambulance Service Clinical Practice Guidelines, Comprehensive edition, December 2021**,[3] the **Collaborative Aotearoa Standing Order Templates for General Practice**, and initial feedback from Te Kaunihera.

Appendix 1 specifies the prescription medicines proposed for the SPML by broad therapeutic group, and their Indication or rationale for inclusion in the SPML.

Appendix 2 summarises the non-prescription medicines (pharmacist only (restricted), pharmacy-only, and general sales medicines) included in the existing paramedic standing orders that paramedic prescribers will be able to prescribe but will not be listed in the SPML.

Additional information

1. The prescription medicines are grouped into therapeutic groups. These are indicative only. The broad classification from the New Zealand Formulary (NZ Formulary) is used. This is not to be taken as an absolute. Similarly, the 'indication' is indicative and does not cover every possible indication, and the indication may vary between paramedic prescriber levels.

2. Some medicines may be indicated for multiple uses, for example, haloperidol may be used as an antipsychotic or in palliative care for the management of nausea and vomiting. The gazetted list generally does not specify a specific indication. Designated prescribers must be aware of all medicines that are on their gazetted list and through agreement with their collaborative team and/or mentor decide which medicines are appropriate to be prescribed within the prescriber's area of practice irrespective of the medicine being listed.

3. When gazetted, the chemical name as in the Medicines Regulation 1984 (Schedule 1) will be used. This means that the spelling may differ to that used in the NZ Formulary and/or on medicine labelling. For example, 'bendrofluazide' and 'lignocaine' (both the old British approved names (BAN) used in the

[3] Developed by the National Ambulance Sector Clinical Working Group with representatives from Hato Hone St John, Wellington Free Ambulance, Helicopter Emergency Medical Service (HEMS), Northern Rescue Helicopter, Search and Rescue Servies.

Medicines Regulations) versus 'bendroflumethiazide', and 'lidocaine' (the recognised international non-proprietary name (rINN)) used in the NZ Formulary and on product labelling.

4. Designated prescribers can prescribe non-prescription medicines, including pharmacist only (restricted), pharmacy-only, and general sales medicines. Non-prescription medicines are not included in the SPML. Hence, these medicines are not considered under this consultation.

5. For combination products (eg, adrenaline + lignocaine; dexamethasone + framycetin + gramicidin (Sofradex brand) if any of the active pharmaceutical ingredients are prescription medicines, the individual prescription medicine ingredients must be listed on the SPML before the combination product is available to the designated prescriber to prescribe.

6. Controlled drugs (eg, morphine, tramadol, ketamine) will be listed under a Schedule to the Misuse of Drugs Regulations 1977.

7. Inclusion of a medicine on the gazetted SPML for designated prescribers does not give a designated prescriber automatic approval to prescribe the medicine. At all times, the designated prescriber must operate within legislative frameworks (eg, the Medicines Act and regulations; including not prescribing unapproved medicines (Medicines Act, section 29; unless prescribed under section 29A[4]), funding restrictions (if applicable), within the prescriber's area of practice, experience and competence, within the collaborative team, and within any limits set by the prescriber's mentor.

Listing medicines by class

8. In 2025, in collaboration with the Pharmacy Council and the Nursing Council, before undertaking consultation and revisions to the pharmacist prescriber and nurse prescriber SPMLs, the Ministry thoroughly explored the possibility of using WHO's Anatomical Therapeutic Chemical (ATC) in their SPMLs.

9. Pre-consultation comments suggested that the medicines should be listed in the SPML by therapeutic class, rather than a list of individual medicines. It has been suggested that using medicine classes would future proof the SPML lessening the chances that the SPML goes out of date and the need for updating.

10. The use of the WHO ATC classification is not enabled under the existing legislative settings. Reasons for not using the ATC classification, or a similar classification (for example, the New Zealand Formulary classifications) included the following.
    - The ATC classification does not specify specific medicines or specified classes, which is the intent of the list for designated prescribers under the Medicines Act 1981.

[4] The **Medicines Act 1981, section 29A**, enables an authorised prescriber to prescribed an unapproved medicines when it is listed in the Pharmaceutical Schedule as a funded alternative medicine to an approved medicines when the approved medicine is in short supply.

- The classes include all medicines available internationally, including medicines that are no longer funded or considered best practice in New Zealand.
- The classifications are not closed classes; therefore, it is uncertain what medicines a class contains, and which medicines are available and approved in New Zealand. New types of medicines and classes could be added to these classifications which would not have best-practice guidelines or not have been used sufficiently for the New Zealand population to establish side effects or adverse reactions.
- The ATC classification does not provide enough detail for the public to determine which medicines the designated prescriber can and cannot prescribe.

Specific, well defined and discrete classifications may be used, for example 'vaccines' and 'insulins' without listing the individual vaccines or medicines.

Next steps

This consultation on the development of the SPML for paramedic prescribers is being undertaken in parallel with the activities of Te Kaunihera.

The SPML will not be used until after paramedic prescribers have been enabled by Te Kaunihera.

Several steps are necessary before paramedic prescribing can be initiated (**Figure 1 and Figure 2**), including:

- legislative change (enabling regulations under the Medicines Act 1981)
- consultation on, and gazettal of, the SPML (this consultation)
- amendment to the Misuse of Drugs Regulations 1977 to enable prescribing of controlled drugs
- the development of education, training, qualification, competence, supervision and mentoring, and continuing professional development requirements
- the accreditation of education and training providers
- establishing a paramedic prescriber scope of practice.

After the consultation period ends, all feedback will be reviewed and considered. For prescription medicines that are not controlled drugs, the Director-General of Health will publish the SPML in the Gazette. In the case of controlled drugs, regulations under the Misuse of Drugs Regulation 1977 will be introduced to allow paramedic prescribers to prescribe the specified medicines.

How to provide feedback

Please complete the online survey. Select the 'Share your views' link on the consultation webpage.

Please submit your feedback on the proposed SPML for paramedic prescribers by 5 July 2026.

Figure 1: Te Kaunihera Manapou – the Paramedic Council's responsibilities to enable paramedic prescribing

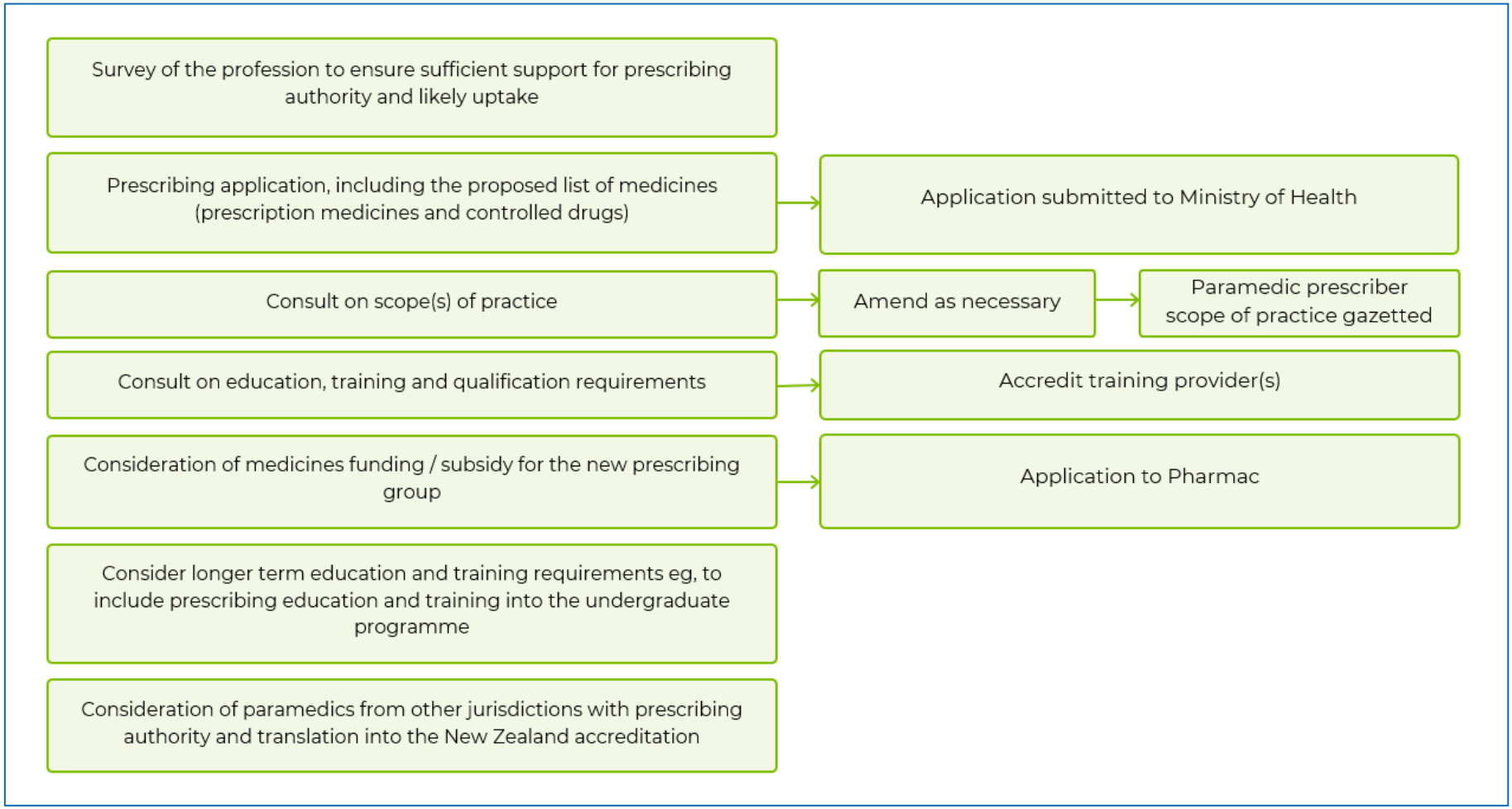
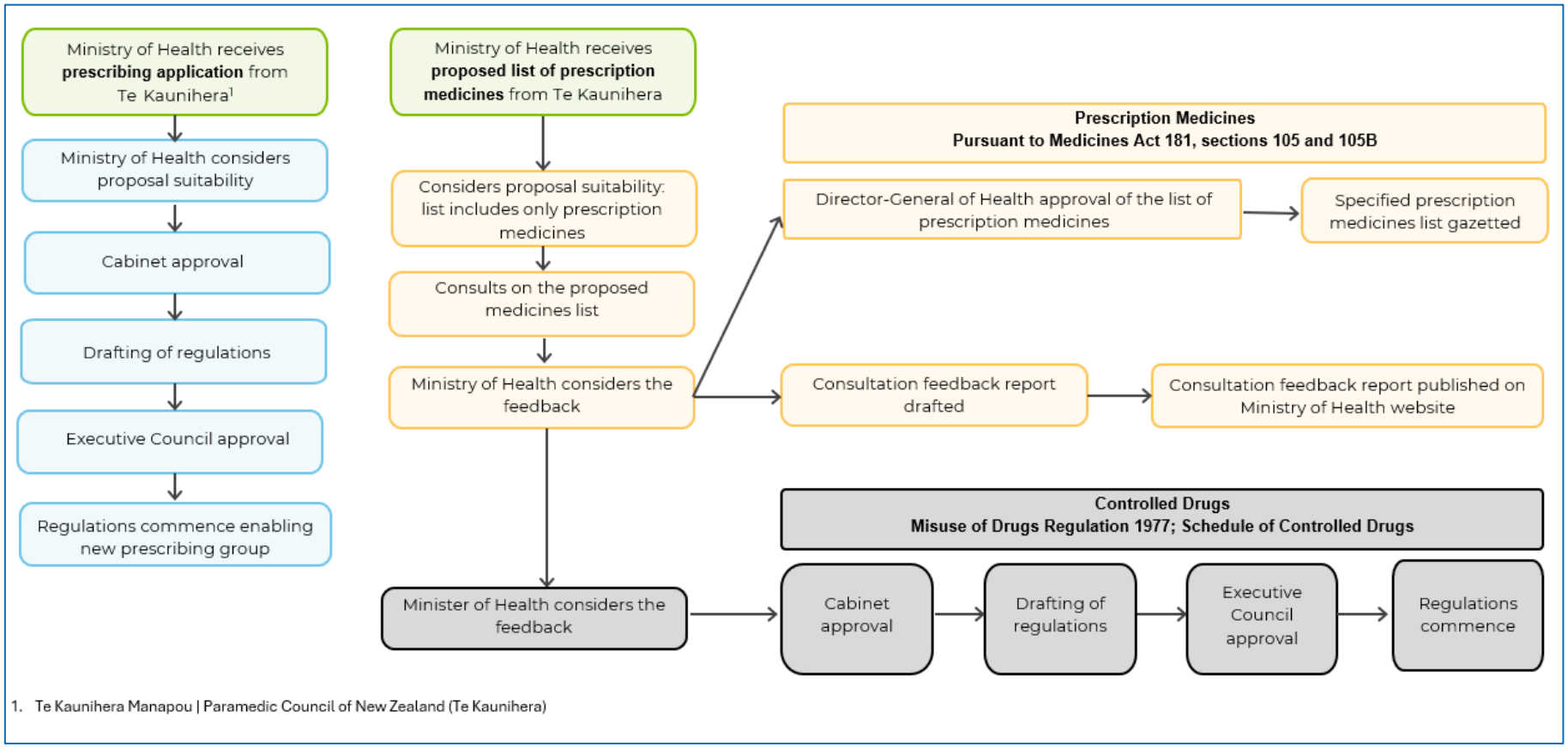


Figure 2: Ministry of Health's and the Minister of Health's responsibilities to enable paramedic prescribing



1. Te Kaunihera Manapou | Paramedic Council of New Zealand (Te Kaunihera)

Appendix 1: The proposed prescription medicines for paramedic prescribers

Proposed prescription medicines for the paramedic prescriber specified prescription medicines list by broad therapeutic group and indicative use (subject to Director-General of Health approval)

It is proposed that a single specified prescription medicine list will be gazetting, from which the Paramedic Council will derive and maintain sub-lists of medicines and corresponding indications for each paramedic prescriber level.

Broad therapeutic group[5]	Proposed prescription medicine	Indication / rationale for inclusion (based on the existing standing orders)[6]
Anaesthesia		
Antimuscarinic drugs	Atropine	• Sinus bradycardia, nodal bradycardia, 1st degree heart block, 2nd degree heart block or an undifferentiated narrow complex bradycardia • Organophosphate poisoning
Drugs for opioid antagonism	Naloxone	Opioid overdose
Local anaesthesia	Articaine	Dental block (with adrenaline)
	Lignocaine (lidocaine)	• Subcutaneous infiltration for local anaesthesia: field block, digital ring block, dental block

[5] As listed in the New Zealand Formulary (NZF). NZF v167. 2026. Available from: **www.nzf.org.nz** (accessed May 2026).

[6] Based on the existing Hato Hone St John standing orders and the 'Collaborative Aotearoa Standing Orders (Standing Order Templates for General Practice [Internet]. Collaborative Aotearoa; Available from: **https://collab.org.nz/wp-content/uploads/2024/11/General-Practice-Standing-Order-Templates-2024-1.pdf**). The Paramedic Council will maintain the list of specific indications for each paramedic prescriber level.

Broad therapeutic group[5]	Proposed prescription medicine	Indication / rationale for inclusion (based on the existing standing orders)[6]
		• Subcutaneous injection for prophylaxis of pain associated with IV cannulation • Subcutaneous injection for digital ring blocks for analgesia • Intraosseous injection for bone pain associated with fluid infusion via an intraosseous needle • (with chlorhexidine) urinary catheter and nasogastric tube placement • (with phenylephrine) moderate to severe epistaxis; prior to dental block • (with fluorescein) suspected corneal abrasions and/or corneal foreign bodies
	Ropivacaine	• Severe pain associated with clinically obvious fractured neck of femur or fractured proximal shaft of femur • Moderate to severe pain associated with isolated injuries to digits • Blocks; fascia iliac, digital ring block, dental block, ankle block
Neuromuscular blocking drugs	Rocuronium	• Neuromuscular blockade following endotracheal intubation • Patient movement during cardiac arrest that is interfering with resuscitation, despite ketamine administration, provided the patient has been intubated and the endotracheal tube position has been confirmed with capnography
	Suxamethonium	Rapid sequence intubation (RSI)
Non-opioid analgesics	Celecoxib	Mild to moderate pain
	Diclofenac	
	Ibuprofen	
	Naproxen	
	Parecoxib	• Pain associated with renal colic • Headache

Broad therapeutic group[5]	Proposed prescription medicine	Indication / rationale for inclusion (based on the existing standing orders)[6]
		• Gout • Non-traumatic lumbar back pain • Other painful conditions where a strong NSAID may be useful
Volatile liquid anaesthetics	Methoxyflurane	Moderate to severe analgesia
	Nitrous oxide	• As Entonox (nitrous oxide + oxygen) • Alternative to methoxyflurane in cases of supply chain disruption • Entonox is much more commonly used in primary care than methoxyflurane
Cardiovascular system		
Cardiovascular system	Captopril	• Heart failure • Hypertension
	Enalapril	
	Lisinopril	
	Perindopril	
	Quinapril	
	Ramipril	
Cardiovascular system	Candesartan	• Heart failure • Hypertension
	Irbesartan	
	Losartan	
Cardiovascular system	Enoxaparin	ST-segment elevation myocardial infarction (STEMI)
	Heparin	
Cardiovascular system	Tranexamic acid	• Postpartum haemorrhage

Broad therapeutic group[5]	Proposed prescription medicine	Indication / rationale for inclusion (based on the existing standing orders)[6]
		• Clinically significant bleeding or signs of hypovolaemia following trauma • Non-traumatic bleeding and shock is severe • Cardiac arrest secondary to trauma • Bleeding following tonsillectomy • Crush injury • Moderate to severe epistaxis • Antepartum haemorrhage if shock and/or bleeding is severe • Persistent minor bleeding, for example, from superficial wounds, anterior epistaxis, stoma site
Antiplatelet drugs	Clopidogrel	STEMI
	Rivaroxaban	Treatment of deep-vein thrombosis
	Ticagrelor	Myocardial infarction
Beta-adrenoceptor blocking drugs	Bisoprolol	• Alternative to metoprolol in supply chain disruption
	Labetalol	• Control of hypertension prior to fibrinolytic treatment for STEMI • Control of hypertension during inter-hospital transfer for STEMI • Control of hypertension during inter-hospital transfer for stroke clot retrieval • Control of hypertension associated with autonomic dysreflexia
	Metoprolol	Fast atrial fibrillation or atrial flutter
Calcium-channel blockers	Amlodipine	Adults with severe hypertension who are not immediately being referred to an ED
Diuretics	Furosemide	To enable an ECP to start someone on a trial of frusemide or adjust a person's frusemide dosing (eg, for people who are already taking it and present with increased breathlessness/signs of fluid overload)

Broad therapeutic group[5]	Proposed prescription medicine	Indication / rationale for inclusion (based on the existing standing orders)[6]
Drugs for arrhythmias	Adenosine	Supraventricular tachycardia
	Amiodarone	• Cardiac arrest with VF or VT at any time after the first dose of adrenaline • Sustained VT in absence of cardiac arrest • Moderate cardiovascular compromise as a result of fast atrial fibrillation or fast atrial flutter
Fibrinolytic drugs	Alteplase	To enable a CCPs to continue/adjust an alteplase infusion for a patient with acute stroke being transferred between hospitals (eg, for clot retrieval)
	Tenecteplase	Thrombolysis post myocardial infarction
Lipid-regulating drugs	Atorvastatin	Hypercholesterolaemia and hyperlipidaemia
	Ezetimibe	
	Simvastatin	
Nitrates	Glyceryl trinitrate	• Cardiogenic pulmonary oedema • Control of hypertension associated with autonomic dysreflexia • Control of hypertension prior to fibrinolytic treatment for STEMI • Control of hypertension during inter-hospital transfer for STEMI • Control of hypertension during inter-hospital transfer for stroke clot retrieval
Sympathomimetics	Adrenaline	• Cardiopulmonary resuscitation • Anaphylaxis • Severe asthma • Imminent respiratory arrest from COPD • Severe bradycardia • Blood pressure support if unresponsive to metaraminol

Broad therapeutic group[5]	Proposed prescription medicine	Indication / rationale for inclusion (based on the existing standing orders)[6]
		• Septic shock, cardiogenic shock and neurogenic shock unresponsive to sodium chloride 0.9% IV and metaraminol IV • Moderate to severe stridor • Intranasal clinically significant epistaxis • Topical for clinically significant bleeding from a wound • Subcutaneous infiltration for local anaesthesia: field block, digital ring block, dental block
	Metaraminol	Hypotension in the setting of septic shock, post cardiac arrest, cardiogenic shock, severe traumatic brain injury, neurogenic shock, rapid sequence intubation and post intubation
	Noradrenaline	• Alternative to metaraminol during supply chain shortages • Enables CCPs to continue/adjust a noradrenaline infusion started by hospital clinicians when transferring someone between hospitals
Central nervous system		
Acute migraine	Rizatriptan	• Acute migraine
	Sumatriptan	
Antidepressant drugs	Amitriptyline	Treatment of sciatic nerve pain secondary to muscle spasm
	Nortriptyline	
Anti-seizure medicine	Levetiracetam	• Seizure that continues or recurs after two doses of parenteral midazolam • Seizure activity associated with severe traumatic brain injury, even if seizure activity has ceased following midazolam
	Valproic acid	Alternative to levetiracetam in cases of supply chain disruption

Broad therapeutic group[5]	Proposed prescription medicine	Indication / rationale for inclusion (based on the existing standing orders)[6]
	(Sodium valproate)	
Drugs used in nausea and vertigo	Cyclizine	Nausea and vomiting
	Metoclopramide	
	Ondansetron	
	Prochlorperazine	
Other analgesics and adjuvants	Pregabalin	• Chronic or persistent neuropathic pain • Shingles with pain not managed with simple oral analgesia
Palliative care	Levomepromazine	• Agitation during end-of-life care that is not rapidly managed by midazolam • Breakthrough nausea and/or vomiting in end-of-life care not well controlled with droperidol
Phenothiazines and related drugs	Droperidol	• Agitated delirium • Nausea or vomiting during palliative and end of life care • Chronic or persistent pain • Cannabinoid hyperemesis • Headache with nausea and vomiting
	Haloperidol	• Alternative to droperidol in cases of supply chain disruption • Palliative care
Second-generation (atypical) antipsychotic drugs	Olanzapine	Acute behavioural disturbance
Ear, nose, and oropharynx		
Anti-infective preparations	Ciprofloxacin; ophthalmic and otic use only	Otitis externa

Broad therapeutic group[5]	Proposed prescription medicine	Indication / rationale for inclusion (based on the existing standing orders)[6]
		For example, Ciproxin-HC, combination product
	Clioquinol	For example, Locorten-Vioform, combination product
	Dexamethasone	
	Flumethasone (flumetasone)	For example, Locorten-Vioform, combination product
	Framycetin	For example, Sofradex, combination product
	Gramicidin	For example, Sofradex, combination product
	Hydrocortisone	For example, Ciproxin-HC, combination product
	Neomycin	For example, Kenacomb, combination product
	Nystatin	For example, Kenacomb, combination product
	Triamcinolone acetonide	
Endocrine system		
Corticosteroids	Dexamethasone	Croup and asthma exacerbation
	Hydrocortisone	• Adrenal crisis or suspected adrenal crisis • Adults with angioedema occurring during inter-hospital transfer for stroke clot retrieval • Bronchospasm associated with asthma or COPD • Mild to moderate exacerbation of COPD • Croup • Minor allergy associated with rash • Acute gout
	Prednisone	
	Prednisolone	
Diabetes mellitus	Gliclazide	Management of diabetes mellitus

Broad therapeutic group[5]	Proposed prescription medicine	Indication / rationale for inclusion (based on the existing standing orders)[6]
	Insulins (as a class)	
	Metformin	
Eye		
Local anaesthetic	Amethocaine (tetracaine)	Ocular anaesthetic for inspection and removal of foreign body
Gastro-intestinal system		
Antisecretory drugs and mucosal protectants	Lansoprazole	Therapeutic trial to aid in the diagnosis of GORD
	Omeprazole	
	Pantoprazole	
Antispasmodics and other drugs altering gut motility	Hyoscine butylbromide	• Excessive oral secretions in the unconscious patient during end-of-life care • Abdominal colic during end-of-life care • Abdominal colic due to muscle spasm of the GI tract
Infections		
Antibacterial drugs	Amoxicillin	• COPD and increased sputum purulence, increased sputum volume, or increased breathlessness • Mild to moderate community acquired pneumonia • Throat infection and Group A streptococcal (GAS) pharyngitis is likely, or high risk for rheumatic fever, or it is highly likely patient will be lost to follow up • Epistaxis with nasal packing and packing will be in place for greater than 24 hours, or patient Is immunocompromised, or patient has heart valve replacement • Dental abscess and risk factors for infection • Otitis media with suspected bacterial infection

Broad therapeutic group[5]	Proposed prescription medicine	Indication / rationale for inclusion (based on the existing standing orders)[6]
	Azithromycin	Suspected chlamydia or gonorrhoea infection
	Benzathine penicillin (benzathine benzylpenicillin tetrahydrate)	• Throat infection and high risk of failing to attend follow up and: – GAS pharyngitis is likely (score ≥ 4), or – High risk for rheumatic heart fever (score ≥ 2) • Primary syphilis
	Cefalexin	• Urinary tract infection • Allergic to penicillin and epistaxis with nasal packing and in place for > 24 hours, or immunocompromised, or heart valve replacement • Allergic to penicillin and throat infection and GAS pharyngitis is likely, or high risk for rheumatic fever, or high risk of failing to follow up • Allergic to penicillin and dental abscess and delays accessing dental care, or severe or spreading infection, or immunocompromised • Allergic to penicillin and otitis media with suspected bacterial infection • Allergic to penicillin and otitis externa and not improving after topical treatment for 48 hours, or infection visible on external auditory meatus or lobe • Allergic to penicillin and abscess requiring antibiotics and the patient has MRSA. • Child and mild to moderate UTI • Child and throat infection and allergic to penicillin and GAS pharyngitis is likely (score ≥ 4), or high risk for rheumatic fever (score ≥ 2) • Child and abscess requiring antibiotics • Child and otitis externa and not improving after topical treatment for 48 hours, or infection visible on external auditory meatus or lobe • Child and mild to moderate cellulitis

Broad therapeutic group[5]	Proposed prescription medicine	Indication / rationale for inclusion (based on the existing standing orders)[6]
		• Child and minor burns with infection and not immediately being referred to an ED • Child and lacerations with infection or requiring prophylactic antibiotics
	Cefazolin	• Bacterial sepsis • Cellulitis
	Ceftriaxone	• Suspected meningococcal septicaemia • Bacterial sepsis when cefazolin is not indicated • Urinary catheter placement in a patient with risks for infective endocarditis or infective prosthesis • Moderate uncomplicated pyelonephritis • Suspected chlamydia or gonorrhoea infection
	Clavulanic acid	• With amoxycillin as amoxicillin + clavulanic acid • COPD with atypical bacterial infection or no improvement with first line therapy • Mild to moderate community acquired aspiration pneumonia • Diverticulitis with features of infection • Mild to moderate uncomplicated pyelonephritis • Mammal bites requiring prophylactic antibiotics • Stoma site infection • Penetrating foot injury from a nail and the patient is not immediately being referred
	Clindamycin	Cellulitis in patients with anaphylaxis to penicillin or cephalosporin, or unable to take probenecid

Broad therapeutic group[5]	Proposed prescription medicine	Indication / rationale for inclusion (based on the existing standing orders)[6]
	Doxycycline	• COPD with increased sputum purulence, increased sputum volume, or increased breathlessness • Mild to moderate community acquired pneumonia if patient is allergic to penicillin or if Legionella or other atypical organisms are suspected • Suspected chlamydia or gonorrhoea infection
	Erythromycin	Penicillin allergy and dental abscess
	Flucloxacillin	• Otitis externa visible externally or not improving with 48 hours of topical treatment • Abscess or paronychia associated with fever, or spreading cellulitis, or comorbidity • Complicated abscess not immediately being referred to a medical facility • Inflammatory mass with unsuccessful drainage • Mild to moderate cellulitis • Severe cellulitis managed in the community and a delay pursuing a local pathway for IV antibiotics • Skin tears with infection or requiring prophylactic antibiotics • Minor burns with infection and not immediately being referred to an ED • Laceration with infection or requiring prophylactic antibiotics
	Gentamicin	Pyelonephritis
	Metronidazole	• Mild community-acquired aspiration pneumonia and allergic to penicillin • Diverticulitis with features of infection and allergic to penicillin • Dental abscess and risk factors for infection • Mammal bite requiring antibiotic prophylaxis and allergic to penicillin

Broad therapeutic group[5]	Proposed prescription medicine	Indication / rationale for inclusion (based on the existing standing orders)[6]
	Nitrofurantoin	• Urinary tract infection • Following urinary catheter placement if the patient has a history of symptomatic UTI or sepsis after previous catheter changes, or there has been a traumatic insertion (frank haematuria following catheter placement, or greater than one attempt)
	Phenoxymethylpenicillin (Penicillin V)	Sore throat in patients at risk of rheumatic fever (age 3-35 years and assessed as likely to take medication reliably)
	Roxithromycin	• Allergic to penicillin and: • mild to moderate community-acquired pneumonia; throat infection; dental abscess; moderate cellulitis; severe cellulitis and delay in pursuing a local pathway for IV antibiotics; laceration requiring antibiotics; or skin tear requiring antibiotics
	Sulfamethoxazole	• Adults allergic to penicillin and: mild community-acquired aspiration pneumonia; diverticulitis with features of infection; mild to moderate uncomplicated pyelonephritis; stoma site infection; mild to moderate UTI; COPD and atypical organisms; mammal bite requiring antibiotic prophylaxis; penetrating foot injury from a nail; cutaneous abscess or paronychia requiring antibiotics • Children allergic to penicillin and: mild to moderate UTI; cutaneous or paronychia requiring antibiotics; site infection; mammal bite requiring antibiotic; penetrating foot injury from nail
	Trimethoprim	As for sulfamethoxazole
	Probenecid	Adjunct to beta-lactam antibiotic treatment
Antifungal drugs	Fluconazole	Candidiasis

Broad therapeutic group[5]	Proposed prescription medicine	Indication / rationale for inclusion (based on the existing standing orders)[6]
Antiviral drugs	Aciclovir	Alternative to valaciclovir in cases of supply chain disruption
	Nirmatrelvir	COVID-19 infection
	Ritonavir	COVID-19 infection
	Valaciclovir	• Shingles (herpes zoster) and treatment is initiated within 72 hours of symptom onset, or new lesions are appearing • Suspected genital herpes (herpes simplex) if patient cannot be seen by their usual primary care provider or sexual health practitioner within 24 hours and treatment is initiated within 5 days of symptoms onset
Musculoskeletal and joint diseases		
Gout	Allopurinol	Management of gout
	Colchicine	
Skeletal muscle relaxants	Orphenadrine	Symptomatic relief of acute muscle spasm
Nutrition and blood		
Fluids and electrolytes	Sodium bicarbonate	• Release syndrome following crush injury in an adult • Known or suspected hyperkalaemia with severe ECG changes • Cardiac arrest secondary to hyperkalaemia • Suspected cyclic antidepressant poisoning with QRS prolongation • Severe traumatic brain injury and intubated with clinical signs of raised intracranial pressure.
Obstetrics, gynaecology, and urinary-tract disorders		
Drugs used in obstetrics	Oxytocin	• Delivery of the placenta • Postpartum haemorrhage

Broad therapeutic group[5]	Proposed prescription medicine	Indication / rationale for inclusion (based on the existing standing orders)[6]
Emergency contraception	Levonorgestrel	Emergency contraception
Oral contraceptives	Ethinylestradiol	Contraception
	Levonorgestrel	
	Norethisterone	
Respiratory system		
Antihistamines	Promethazine	Angioedema occurring during inter-hospital transfer for stroke clot retrieval
Bronchodilators	Budesonide	Mild to moderate asthma in patients aged 12 years or greater, for use after initial control of symptoms has been achieved.
	Formoterol	Mild to moderate asthma in patients aged 12 years or greater, for use after initial control of symptoms has been achieved.
	Ipratropium	• Asthma or chronic obstructive pulmonary disease (COPD) • Bronchospasm secondary to airway burns, smoke inhalation or chest infection
	Salbutamol	• Bronchospasm secondary to asthma or COPD • Pertinent bronchospasm secondary to airway burns, smoke inhalation or chest infection • Release syndrome following crush injury • Known or suspected hyperkalaemia with ECG changes
Skin		
Antifungal preparations	Ketoconazole; topical use only	Seborrhoeic dermatitis
Topical corticosteroids	Mometasone	Active eczema- severe
	Triamcinolone	

Broad therapeutic group[5]	Proposed prescription medicine	Indication / rationale for inclusion (based on the existing standing orders)[6]
Vaccines		
Vaccines	Vaccines	Vaccines as a class to enable participation in the national immunisation programme
Controlled drugs		
Benzodiazepines	Lorazepam	Acute anxiety causing distress
	Midazolam	• Generalised seizures that continue for more than five minutes, or seizures are recurrent • Acute behavioural disturbance causing mild to moderate risk to safety and droperidol is unavailable or ineffective • Control of anxiety or shortness of breath that does not respond to an opioid during end-of-life care • Breakthrough symptoms of agitation, myoclonic jerks or seizure activity during end-of-life care • Pain associated with severe muscle spasm or severe anxiety if adequate analgesia is not being achieved with an opioid and ketamine is not appropriate • Sedation, for example, for joint relocation • Severe anxiety associated with COPD • Severe end-stage COPD that is being managed conservatively • Severe muscle spasm in non-traumatic lower back pain
NMDA-receptor antagonists	Ketamine	• Severe pain • Inducing dissociation (pre-procedure) • Agitated delirium causing severe to immediately life-threatening risk to safety • Rapid sequence intubation

Broad therapeutic group[5]	Proposed prescription medicine	Indication / rationale for inclusion (based on the existing standing orders)[6]
		• Significant movement during CPR that is interfering with resuscitation • Asthma with severe agitation that is impairing ability to safely provide treatment and/or transport
Opioids	Codeine	• Moderate to severe pain not responding to initial analgesic options • Severe diarrhoea in adults if loperamide is not available
	Fentanyl	• Moderate to severe pain • Cardiogenic pulmonary oedema with severe anxiety • Rapid sequence intubation • Sedation post intubation • Symptom control during end-of-life care
	Morphine	• Moderate to severe pain • Cardiogenic pulmonary oedema with severe anxiety • Control of pain, agitation, or shortness of breath during end-of-life care • Autonomic dysreflexia, even if patient cannot feel pain
	Oxycodone	Moderate to severe pain
	Tramadol	Moderate to severe pain

Appendix 2: Non-prescription medicines

Non-prescription medicines may be prescribed by designated paramedic prescribers

Designated prescribers can prescribe non-prescription medicines (eg, pharmacist only (restricted), pharmacy-only, and general sales medicines). This table summarises the non-prescription medicines included in the existing paramedic standing orders that will not be listed in the specified prescription medicines list.

Non-prescription medicines
Alginate sodium + calcium carbonate + sodium bicarbonate (eg, Acidex)
Aqueous cream
Aspirin
Bisacodyl
Calcium chloride
Cetirizine
Cetomacrogol
Chloramphenicol
Chlorhexidine
Citrate sodium (eg, in Microlette)
Clotrimazole
Cromoglycate sodium
Dimeticone
Docusate sodium
Fluticasone
Folic acid
Glucagon
Glucose
Glycerol (glycerine)
Hydrogen peroxide
Ibuprofen
Lauryl sulfoacetate sodium

Non-prescription medicines
Lignocaine + tetracaine + adrenaline (eg, Topicaine)
Loperamide
Loratadine
Macrogol
Magnesium sulphate
Mebendazole
Miconazole
Nystatin
Permethrin
Phenylephrine
Oral Rehydration Formula (eg, Electral, Enerlyte, Padialyte)
Oxygen
Paracetamol
Paraffin liquid
Paraffin soft
Phosphate sodium dibasic
Phosphate sodium monobasic
psyllium husk powder
Sennoside B
Sodium chloride
Sorbitol
Zinc with castor oil