

November 2018

Volume 25 Number 2

Editors:

Kaye Wilson & Doris Chong
email: enquiry@pharmac.govt.nz
Telephone +64 4 460 4990
Facsimile +64 4 460 4995
Level 9, 40 Mercer Street
PO Box 10 254 Wellington

Freephone Information Line

0800 66 00 50 (9am – 5pm weekdays)

Circulation

Published each April, August and December.
Changes to the contents are published in
monthly updates.

Accessible in an electronic format at no cost
from the Health Professionals section of the
PHARMAC website www.pharmac.govt.nz

You can register to have an electronic version
of the Pharmaceutical Schedule (link to
PDF copy) emailed to your nominated email
address each month. Alternatively there is
a nominal charge for an annual subscription
to the printed Schedule publications. To
access either of these subscriptions visit our
subscription website www.schedule.co.nz.

Production

Typeset automatically from XML and TeX.
XML version of the Schedule available from
www.pharmac.govt.nz/pub/schedule/archive/

Programmers

Anrik Drenth & John Geering
email: texschedule@pharmac.govt.nz

©Pharmaceutical Management Agency



ISSN 1179-3686 pdf
ISSN 1172-9376 print

This work is licensed under the Creative
Commons Attribution 4.0 International licence.

In essence, you are free to copy, distribute
and adapt it, as long as you attribute the work
to PHARMAC and abide by the other licence
terms. To view a copy of this licence, visit:
creativecommons.org/licenses/by/4.0/.

Attribution to PHARMAC should be in
written form and not by reproduction of the
PHARMAC logo. While care has been taken
in compiling this Schedule, PHARMAC takes
no responsibility for any errors or omissions,
and shall not be liable for any consequences
arising there from.

Introducing PHARMAC 2

Section A General Rules 5

Section B Alimentary Tract & Metabolism 6

Blood & Blood Forming Organs 37

Cardiovascular System 47

Dermatologicals 61

Genito Urinary System 72

Hormone Preparations – Systemic 78

Infections – Agents For Systemic Use 90

Musculoskeletal System 112

Nervous System 122

Oncology Agents & Immunosuppressants 155

Respiratory System & Allergies 200

Sensory Organs 208

Various 213

Section C Extemporaneous Compounds (ECPs) 215

Section D Special Foods 218

Section I National Immunisation Schedule 237

Index 248

Introducing PHARMAC

The Pharmaceutical Management Agency (PHARMAC) makes decisions that help control Government spending on pharmaceuticals. This includes community pharmaceuticals, hospital pharmaceuticals, vaccines and increasingly, hospital medical devices. PHARMAC negotiates prices, sets subsidy levels and conditions, and makes decisions on changes to the subsidised list. The funding for pharmaceuticals comes from District Health Boards.

PHARMAC's role:

“Secure for eligible people in need of pharmaceuticals, the best health outcomes that can reasonably be achieved, and from within the amount of funding provided.”

New Zealand Public Health and Disability Act 2000

To ensure our decisions are as fair and robust as possible we use a decision-making process that incorporates clinical, economic and commercial issues. We also seek the views of users and the wider community through consultation. The processes we generally use are outlined in our Operating Policies and Procedures.

Further information about PHARMAC and the way we make funding decisions can be found on the PHARMAC website at <http://www.pharmac.govt.nz/about>.

Purpose of the Pharmaceutical Schedule

The purpose of the Schedule is to list:

- the Community Pharmaceuticals that are subsidised by the Government and to show the amount of the subsidy paid to contractors, as well as the manufacturer's price and any access conditions that may apply;
- the Hospital Pharmaceuticals that may be used in DHB Hospitals, as well as any access conditions that may apply; and
- the Pharmaceuticals, including Medical Devices, used in DHB Hospitals for which national prices have been negotiated by PHARMAC.

The Schedule does not show the final cost to Government of subsidising each Community Pharmaceutical or to DHB Hospitals in purchasing each Pharmaceutical, since that will depend on any rebate and other arrangements PHARMAC has with the supplier and, for Pharmaceuticals used in DHB Hospitals, on any logistics arrangements put in place.

This book contains sections A to D and Section I of the Pharmaceutical Schedule and lists the Pharmaceuticals funded for use in the community, including vaccines, as well as haemophilia and cancer treatments given in DHB hospitals. Section H lists the Pharmaceuticals that can be used in DHB hospitals and is a separate publication.

The Pharmaceuticals in this book are listed by therapeutic group, which is based on the WHO Anatomical Therapeutic Chemical (ATC) system. The listings are displayed alphabetically under each heading.

The index lists both chemical entities and product brand names.

Explaining pharmaceutical entries

The Pharmaceutical Schedule lists pharmaceuticals subsidised by the Government, the subsidy, the supplier's price and the access conditions that may apply.

Example

ANATOMICAL HEADING			
THERAPEUTIC HEADING			
CHEMICAL			
Presentation, form and strength			
10.00	100	Brand A	Brand B
Presentation - Available on a PSO	15.00	50	Brand C
Presentation - Retail pharmacy-specialist	18.00	250 ml OP	Brand D
a) Prescriptions must be written by a paediatrician or paediatric cardiologist; or b) on the recommendation of a paediatrician or a paediatric cardiologist			
CHEMICAL			
Presentation, form and strength			
26.53	100	Brand E	
(35.27)			
Sole Supply			
Fully Subsidised			
Three months supply may be dispensed at one time if endorsed 'certified exemption' by the prescriber or pharmacist.			

Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

Practitioner's Supply Order

Conditions of and restrictions on prescribing (including Special Authority where it applies)

Three months or six months, as applicable, dispensed all-at-once

Brand or manufacturer's name

Sole subsidised supply product

Fully subsidised product

Original Pack - Subsidy is rounded up to a multiple of whole packs

Quantity the Subsidy applies to

Subsidy paid on a product before mark-ups and GST

Manufacturer's Price if different from Subsidy

Glossary

Units of Measure

gram	g	microgram.....	mcg	millimole.....	mmol
kilogram.....	kg	milligram	mg	unit.....	u
international unit.....	iu	millilitre.....	ml		

Abbreviations

Ampoule	Amp	Gelatinous	Gel	Solution.....	Soln
Capsule	Cap	Granules	Gran	Suppository.....	Supp
Cream.....	Crm	Infusion	Inf	Tablet.....	Tab
Device.....	Dev	Injection	Inj	Tincture.....	Tinc
Dispersible.....	Disp	Liquid.....	Liq	Trans Dermal Delivery	
Effervescent.....	Eff	Long Acting.....	LA	System.....	TDDS
Emulsion.....	Emul	Ointment.....	Oint		
Enteric Coated.....	EC	Sachet	Sach		

General Rules for the Pharmaceutical Schedule are located on the PHARMAC website.

SECTION B: ALIMENTARY TRACT AND METABOLISM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

Antacids and Antiflatulents

Antacids and Reflux Barrier Agents

ALGINIC ACID

Sodium alginate 225 mg and magnesium alginate 87.5 mg per sachet.....	5.31	30	✓	Gaviscon Infant
---	------	----	---	-----------------

SODIUM ALGINATE

* Tab 500 mg with sodium bicarbonate 267 mg and calcium carbonate 160 mg - peppermint flavour.....	1.80 (8.60)	60		Gaviscon Double Strength
* Oral liq 500 mg with sodium bicarbonate 267 mg and calcium carbonate 160 mg per 10 ml.....	1.50 (4.95)	500 ml		Acidex

Phosphate Binding Agents

ALUMINIUM HYDROXIDE

* Tab 600 mg	12.56	100	✓	Alu-Tab
--------------------	-------	-----	---	---------

CALCIUM CARBONATE

Oral liq 1,250 mg per 5 ml (500 mg elemental per 5 ml) –				
Subsidy by endorsement	39.00	500 ml	✓	Roxane
Only when prescribed for children under 12 years of age for use as a phosphate binding agent and the prescription is endorsed accordingly.				

Antidiarrhoeals

Agents Which Reduce Motility

LOPERAMIDE HYDROCHLORIDE – Up to 30 cap available on a PSO

* Tab 2 mg	10.75	400	✓	Nodia
* Cap 2 mg	7.05	400	✓	Diamide Relief

Rectal and Colonic Anti-inflammatories

BUDESONIDE

Cap 3 mg – Special Authority see SA1155 below – Retail pharmacy.....	166.50	90	✓	Entocort CIR
--	--------	----	---	--------------

►SA1155 Special Authority for Subsidy

Initial application — (Crohn's disease) from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Mild to moderate ileal, ileocaecal or proximal Crohn's disease; and
- 2 Any of the following:
 - 2.1 Diabetes; or
 - 2.2 Cushingoid habitus; or
 - 2.3 Osteoporosis where there is significant risk of fracture; or

continued...

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
--	---	----------------------------	-------------------------------------

continued...

- 2.4 Severe acne following treatment with conventional corticosteroid therapy; or
- 2.5 History of severe psychiatric problems associated with corticosteroid treatment; or
- 2.6 History of major mental illness (such as bipolar affective disorder) where the risk of conventional corticosteroid treatment causing relapse is considered to be high; or
- 2.7 Relapse during pregnancy (where conventional corticosteroids are considered to be contraindicated).

Initial application — (collagenous and lymphocytic colitis (microscopic colitis)) from any relevant practitioner. Approvals valid for 6 months where patient has a diagnosis of microscopic colitis (collagenous or lymphocytic colitis) by colonoscopy with biopsies.

Initial application — (gut Graft versus Host disease) from any relevant practitioner. Approvals valid for 6 months where patient has a gut Graft versus Host disease following allogeneic bone marrow transplantation*.

Note: Indication marked with * is an unapproved indication.

Renewal from any relevant practitioner. Approvals valid for 6 months where the treatment remains appropriate and the patient is benefiting from treatment.

Note: Clinical trials for Entocort CIR use beyond three months demonstrated no improvement in relapse rate.

HYDROCORTISONE ACETATE

Rectal foam 10%, CFC-Free (14 applications).....	26.55	21.1 g OP	✓ Colifoam
--	-------	-----------	------------

MESALAZINE

Tab 400 mg	49.50	100	✓ Asacol
Tab EC 500 mg	49.50	100	✓ Asamax
Tab long-acting 500 mg.....	59.05	100	✓ Pentasa
Tab 800 mg	85.50	90	✓ Asacol
Modified release granules, 1 g	141.72	120 OP	✓ Pentasa
Enema 1 g per 100 ml	41.30	7	✓ Pentasa
Suppos 500 mg	22.80	20	✓ Asacol
Suppos 1 g	54.60	30	✓ Pentasa

OLSALAZINE

Tab 500 mg	93.37	100	✓ Dipentum
Cap 250 mg	53.00	100	✓ Dipentum

SODIUM CROMOGLICATE

Cap 100 mg	92.91	100	✓ Nalcrom
------------------	-------	-----	-----------

SULFASALAZINE

* Tab 500 mg	14.00	100	✓ <u>Salazopyrin</u>
* Tab EC 500 mg	13.50	100	✓ <u>Salazopyrin EN</u>

Local preparations for Anal and Rectal Disorders

Antihæmorrhoidal Preparations

FLUCORTOLONE CAPROATE WITH FLUCORTOLONE PIVALATE AND CINCHOCAINE

Oint 950 mcg, with flucortolone pivalate 920 mcg, and cinchocaine hydrochloride 5 mg per g.....	6.35	30 g OP	✓ Ultraproct
Suppos 630 mcg, with flucortolone pivalate 610 mcg, and cinchocaine hydrochloride 1 mg	2.66	12	✓ Ultraproct

HYDROCORTISONE WITH CINCHOCAINE

Oint 5 mg with cinchocaine hydrochloride 5 mg per g.....	15.00	30 g OP	✓ Proctosedyl
Suppos 5 mg with cinchocaine hydrochloride 5 mg per g	9.90	12	✓ Proctosedyl

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
---	-----	--------------------------	-------------------------------------

Management of Anal Fissures

GLYCERYL TRINITRATE – Special Authority see [SA1329 below](#) – Retail pharmacy

* Oint 0.2% 22.00 30 g OP ✓ **Rectogesic**

► [SA1329](#) Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid without further renewal unless notified where the patient has a chronic anal fissure that has persisted for longer than three weeks.

Antispasmodics and Other Agents Altering Gut Motility

GLYCOPYRRONIUM BROMIDE

Inj 200 mcg per ml, 1 ml ampoule – Up to 10 inj available on a
PSO 17.14 10 ✓ **Max Health**

HYOSCINE BUTYLBROMIDE

* Tab 10 mg 8.75 100 ✓ **Buscopan**

* Inj 20 mg, 1 ml – Up to 5 inj available on a PSO 9.57 5 ✓ **Buscopan**

MEBEVERINE HYDROCHLORIDE

* Tab 135 mg 18.00 90 ✓ **Colofac**

Antiulcerants

Antisecretory and Cytoprotective

MISOPROSTOL

* Tab 200 mcg 41.50 120 ✓ **Cytotec**

Helicobacter Pylori Eradication

CLARITHROMYCIN

Tab 500 mg – Subsidy by endorsement 10.40 14 ✓ **Apo-Clarithromycin**

a) Maximum of 14 tab per prescription

b) Subsidised only if prescribed for helicobacter pylori eradication and prescription is endorsed accordingly.

Note: the prescription is considered endorsed if clarithromycin is prescribed in conjunction with a proton pump inhibitor and either amoxicillin or metronidazole.

H2 Antagonists

RANITIDINE – Only on a prescription

* Tab 150 mg 12.91 500 ✓ **Ranitidine Relief**

* Tab 300 mg 18.21 500 ✓ **Ranitidine Relief**

* Oral liq 150 mg per 10 ml 5.14 300 ml ✓ **Peptisoothe**

* Inj 25 mg per ml, 2 ml 8.75 5 ✓ **Zantac**

Proton Pump Inhibitors

LANSOPRAZOLE

* Cap 15 mg 4.58 100 ✓ **Lanzol Relief**

* Cap 30 mg 5.41 100 ✓ **Lanzol Relief**

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
OMEPRAZOLE				
For omeprazole suspension refer Standard Formulae, page 215				
* Cap 10 mg.....	1.98	90	✓	Omeprazole actavis 10
* Cap 20 mg.....	1.96	90	✓	Omeprazole actavis 20
* Cap 40 mg.....	3.12	90	✓	Omeprazole actavis 40
* Powder – Only in combination.....	42.50	5 g	✓	Midwest
Only in extemporaneously compounded omeprazole suspension.				
* Inj 40 mg ampoule with diluent.....	33.98	5	✓	Dr Reddy's Omeprazole
PANTOPRAZOLE				
* Tab EC 20 mg.....	2.41	100	✓	Panzop Relief
* Tab EC 40 mg.....	3.35	100	✓	Panzop Relief

Site Protective Agents

COLLOIDAL BISMUTH SUBCITRATE				
Tab 120 mg.....	14.51	50	✓	Gastrodenol <small>\$29</small>
SUCRALFATE				
Tab 1 g.....	35.50 (48.28)	120		Carafate

Bile and Liver Therapy

RIFAXIMIN – Special Authority see SA1461 below – Retail pharmacy				
Tab 550 mg.....	625.00	56	✓	Xifaxan

►SA1461 Special Authority for Subsidy

Initial application only from a gastroenterologist, hepatologist or Practitioner on the recommendation of a gastroenterologist or hepatologist. Approvals valid for 6 months where the patient has hepatic encephalopathy despite an adequate trial of maximum tolerated doses of lactulose.

Renewal only from a gastroenterologist, hepatologist or Practitioner on the recommendation of a gastroenterologist or hepatologist. Approvals valid without further renewal unless notified where the treatment remains appropriate and the patient is benefiting from treatment.

Diabetes

Hyperglycaemic Agents

DIAZOXIDE – Special Authority see SA1320 below – Retail pharmacy				
Cap 25 mg.....	110.00	100	✓	Proglitem <small>\$29</small>
Cap 100 mg.....	280.00	100	✓	Proglitem <small>\$29</small>
Oral liq 50 mg per ml.....	620.00	30 ml OP	✓	Proglycem <small>\$29</small>

►SA1320 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 12 months where used for the treatment of confirmed hypoglycaemia caused by hyperinsulinism.

Renewal from any relevant practitioner. Approvals valid without further renewal unless notified where the treatment remains appropriate and the patient is benefiting from treatment.

GLUCAGON HYDROCHLORIDE				
Inj 1 mg syringe kit – Up to 5 kit available on a PSO.....	32.00	1	✓	Glucagen Hypokit

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
Insulin - Short-acting Preparations				
INSULIN NEUTRAL				
▲ Inj human 100 u per ml.....	25.26	10 ml OP	✓	Actrapid
			✓	Humulin R
▲ Inj human 100 u per ml, 3 ml.....	42.66	5	✓	Actrapid Penfill
			✓	Humulin R
Insulin - Intermediate-acting Preparations				
INSULIN ASPART WITH INSULIN ASPART PROTAMINE				
▲ Inj 100 iu per ml, 3 ml prefilled pen.....	52.15	5	✓	NovoMix 30 FlexPen
INSULIN ISOPHANE				
▲ Inj human 100 u per ml.....	17.68	10 ml OP	✓	Humulin NPH
			✓	Protaphane
▲ Inj human 100 u per ml, 3 ml.....	29.86	5	✓	Humulin NPH
			✓	Protaphane Penfill
INSULIN ISOPHANE WITH INSULIN NEUTRAL				
▲ Inj human with neutral insulin 100 u per ml.....	25.26	10 ml OP	✓	Humulin 30/70
			✓	Mixtard 30
▲ Inj human with neutral insulin 100 u per ml, 3 ml.....	42.66	5	✓	Humulin 30/70
			✓	PenMix 30
			✓	PenMix 40
			✓	PenMix 50
INSULIN LISPRO WITH INSULIN LISPRO PROTAMINE				
▲ Inj lispro 25% with insulin lispro protamine 75% 100 u per ml, 3 ml.....	42.66	5	✓	Humalog Mix 25
▲ Inj lispro 50% with insulin lispro protamine 50% 100 u per ml, 3 ml.....	42.66	5	✓	Humalog Mix 50
Insulin - Long-acting Preparations				
INSULIN GLARGINE				
▲ Inj 100 u per ml, 10 ml.....	63.00	1	✓	Lantus
▲ Inj 100 u per ml, 3 ml.....	94.50	5	✓	Lantus
▲ Inj 100 u per ml, 3 ml disposable pen.....	94.50	5	✓	Lantus SoloStar
Insulin - Rapid Acting Preparations				
INSULIN ASPART				
▲ Inj 100 u per ml, 10 ml.....	30.03	1	✓	NovoRapid
▲ Inj 100 u per ml, 3 ml.....	51.19	5	✓	NovoRapid Penfill
▲ Inj 100 u per ml, 3 ml syringe.....	51.19	5	✓	NovoRapid FlexPen
INSULIN GLULISINE				
▲ Inj 100 u per ml, 10 ml.....	27.03	1	✓	Apidra
▲ Inj 100 u per ml, 3 ml.....	46.07	5	✓	Apidra
▲ Inj 100 u per ml, 3 ml disposable pen.....	46.07	5	✓	Apidra SoloStar
INSULIN LISPRO				
▲ Inj 100 u per ml, 10 ml.....	34.92	10 ml OP	✓	Humalog
▲ Inj 100 u per ml, 3 ml.....	59.52	5	✓	Humalog

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
Alpha Glucosidase Inhibitors				
ACARBOSE				
* Tab 50 mg	3.50	90	✓	<u>Glucobay</u>
* Tab 100 mg	6.40	90	✓	<u>Glucobay</u>
Oral Hypoglycaemic Agents				
GLIBENCLAMIDE				
* Tab 5 mg	6.00	100	✓	<u>Daonil</u>
GLICLAZIDE				
* Tab 80 mg	10.29	500	✓	<u>Glizide</u>
GLIPIZIDE				
* Tab 5 mg	3.27	100	✓	<u>Minidiab</u>
Minidiab to be Sole Supply on 1 January 2019				
METFORMIN HYDROCHLORIDE				
* Tab immediate-release 500 mg	8.63	1,000	✓	<u>Apotex</u>
	9.59		✓	<u>Metchek</u>
* Tab immediate-release 850 mg	7.82	500	✓	<u>Metformin Mylan</u>
PIOGLITAZONE				
* Tab 15 mg	3.47	90	✓	<u>Vexazone</u>
* Tab 30 mg	5.06	90	✓	<u>Vexazone</u>
* Tab 45 mg	7.10	90	✓	<u>Vexazone</u>
VILDAGLIPTIN				
Tab 50 mg	40.00	60	✓	<u>Galvus</u>
VILDAGLIPTIN WITH METFORMIN HYDROCHLORIDE				
Tab 50 mg with 1,000 mg metformin hydrochloride	40.00	60	✓	<u>Galvumet</u>
Tab 50 mg with 850 mg metformin hydrochloride	40.00	60	✓	<u>Galvumet</u>

Diabetes Management

Ketone Testing

BLOOD KETONE DIAGNOSTIC TEST STRIP – Subsidy by endorsement

- Not on a BSO
- Maximum of 20 strip per prescription
- Up to 10 strip available on a PSO
- Patient has any of the following:
 - type 1 diabetes; or
 - permanent neonatal diabetes; or
 - undergone a pancreatectomy; or
 - cystic fibrosis-related diabetes; or
 - metabolic disease or epilepsy under the care of a paediatrician, neurologist or metabolic specialist.

The prescription must be endorsed accordingly.

Test strips 15.50 10 strip OP ✓ KetoSens

SODIUM NITROPRUSSIDE – Maximum of 50 strip per prescription

* Test strip – Not on a BSO 22.00 50 strip OP ✓ Ketostix

(Ketostix Test strip to be delisted 1 February 2019)

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
---	----------------------------	-------------------------------------

Dual Blood Glucose and Blood Ketone Testing

DUAL BLOOD GLUCOSE AND BLOOD KETONE DIAGNOSTIC TEST METER – Subsidy by endorsement

- Maximum of 1 pack per prescription
- Up to 1 pack available on a PSO
- A dual blood glucose and blood ketone diagnostic test meter is subsidised for a patient who has:
 - type 1 diabetes; or
 - permanent neonatal diabetes; or
 - undergone a pancreatectomy; or
 - cystic fibrosis-related diabetes; or
 - metabolic disease or epilepsy under the care of a paediatrician, neurologist or metabolic specialist.

The prescription must be endorsed accordingly. Only 1 meter per patient will be subsidised (no repeat prescriptions). For the avoidance of doubt patients who have previously received a funded meter, other than CareSens, are eligible for a funded CareSens meter.

Meter with 50 lancets, a lancing device and 10 blood glucose

diagnostic test strips.....	20.00	1 OP	✓ <u>CareSens Dual</u>
-----------------------------	-------	------	------------------------

Blood Glucose Testing

BLOOD GLUCOSE DIAGNOSTIC TEST METER – Subsidy by endorsement

- Maximum of 1 pack per prescription
- Up to 1 pack available on a PSO
- A diagnostic blood glucose test meter is subsidised for a patient who:
 - is receiving insulin or sulphonylurea therapy; or
 - is pregnant with diabetes; or
 - is on home TPN at risk of hypoglycaemia or hyperglycaemia; or
 - has a genetic or an acquired disorder of glucose homeostasis, excluding type 1 or type 2 diabetes and metabolic syndrome.

The prescription must be endorsed accordingly. Only one CareSens meter per patient will be subsidised (no repeat prescriptions). Patients already using the CareSens N POP meter and CareSens N meter are not eligible for a new meter, unless they have:

- type 1 diabetes; or
- permanent neonatal diabetes; or
- undergone a pancreatectomy; or
- cystic fibrosis-related diabetes.

For the avoidance of doubt patients who have previously received a funded meter, other than CareSens, are eligible for a funded CareSens meter.

Meter with 50 lancets, a lancing device and 10 diagnostic test

strips.....	10.00	1 OP	✓ <u>CareSens N</u>
			✓ <u>CareSens N POP</u>
	20.00		✓ <u>CareSens N Premier</u>

Note: Only 1 meter available per PSO

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
	✓	

BLOOD GLUCOSE DIAGNOSTIC TEST STRIP – Up to 50 test available on a PSO

The number of test strips available on a prescription is restricted to 50 unless:

- 1) Prescribed for a patient on insulin or a sulphonylurea and endorsed accordingly. Pharmacists may annotate the prescription as endorsed where there exists a record of prior dispensing of insulin or sulphonylurea; or
- 2) Prescribed on the same prescription as insulin or a sulphonylurea in which case the prescription is deemed to be endorsed; or
- 3) Prescribed for a pregnant woman with diabetes and endorsed accordingly; or
- 4) Prescribed for a patient on home TPN at risk of hypoglycaemia or hyperglycaemia and endorsed accordingly; or
- 5) Prescribed for a patient with a genetic or an acquired disorder of glucose homeostasis excluding type 1 or type 2 diabetes and metabolic syndrome and endorsed accordingly.

Test strips	10.56	50 test OP	✓ CareSens N ✓ CareSens PRO
-------------------	-------	------------	--

BLOOD GLUCOSE TEST STRIPS (VISUALLY IMPAIRED)

The number of test strips available on a prescription is restricted to 50 unless:

- 1) Prescribed for a patient on insulin or a sulphonylurea and endorsed accordingly. Pharmacists may annotate the prescription as endorsed where there exists a record of prior dispensing of insulin or sulphonylurea; or
- 2) Prescribed on the same prescription as insulin or a sulphonylurea in which case the prescription is deemed to be endorsed; or
- 3) Prescribed for a pregnant woman with diabetes and endorsed accordingly; or
- 4) Prescribed for a patient on home TPN at risk of hypoglycaemia or hyperglycaemia and endorsed accordingly; or
- 5) Prescribed for a patient with a genetic or an acquired disorder of glucose homeostasis excluding type 1 or type 2 diabetes and metabolic syndrome and endorsed accordingly.

Blood glucose test strips.....	26.20	50 test OP	✓ SensoCard
--------------------------------	-------	------------	--------------------

Insulin Syringes and Needles

Subsidy is available for disposable insulin syringes, needles, and pen needles if prescribed on the same form as the one used for the supply of insulin or when prescribed for an insulin patient and the prescription is endorsed accordingly. Pharmacists may annotate the prescription as endorsed where there exists a record of prior dispensing of insulin.

INSULIN PEN NEEDLES – Maximum of 100 dev per prescription

* 29 g x 12.7 mm	10.50	100	✓ B-D Micro-Fine
* 31 g x 5 mm	11.75	100	✓ B-D Micro-Fine
* 31 g x 6 mm	10.50	100	✓ ABM
* 31 g x 8 mm	10.50	100	✓ B-D Micro-Fine
* 32 g x 4 mm	10.50	100	✓ B-D Micro-Fine

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

* Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
INSULIN SYRINGES, DISPOSABLE WITH ATTACHED NEEDLE – Maximum of 100 dev per prescription				
* Syringe 0.3 ml with 29 g x 12.7 mm needle	13.00	100	✓	B-D Ultra Fine
	1.30	10		
	(1.99)			B-D Ultra Fine
* Syringe 0.3 ml with 31 g x 8 mm needle	13.00	100	✓	B-D Ultra Fine II
	1.30	10		
	(1.99)			B-D Ultra Fine II
* Syringe 0.5 ml with 29 g x 12.7 mm needle	13.00	100	✓	B-D Ultra Fine
	1.30	10		
	(1.99)			B-D Ultra Fine
* Syringe 0.5 ml with 31 g x 8 mm needle	13.00	100	✓	B-D Ultra Fine II
	1.30	10		
	(1.99)			B-D Ultra Fine II
* Syringe 1 ml with 29 g x 12.7 mm needle	13.00	100	✓	B-D Ultra Fine
	1.30	10		
	(1.99)			B-D Ultra Fine
* Syringe 1 ml with 31 g x 8 mm needle	13.00	100	✓	B-D Ultra Fine II
	1.30	10		
	(1.99)			B-D Ultra Fine II

Insulin Pumps

INSULIN PUMP – Special Authority see [SA1603 below](#) – Retail pharmacy

- Maximum of 1 dev per prescription
- Only on a prescription
- Maximum of 1 insulin pump per patient each four year period.

Min basal rate 0.001 U/h	4,500.00	1	✓	Tandem t:slim X2
Min basal rate 0.025 U/h	8,800.00	1	✓	MiniMed 640G

➔SA1603 Special Authority for Subsidy

Initial application — (permanent neonatal diabetes) only from a relevant specialist or nurse practitioner. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- Patient has permanent neonatal diabetes; and
- A MDI regimen trial is inappropriate; and
- Has been evaluated by the multidisciplinary team for their suitability for insulin pump therapy; and
- Patient/Parent/Guardian has undertaken carbohydrate counting education (either a carbohydrate counting course or direct education from an appropriate health professional); and
- Applicant is part of a multidisciplinary team experienced in the management of type 1 diabetes care; and
- Either:
 - Applicant is a relevant specialist; or
 - Applicant is a nurse practitioner working within their vocational scope.

Renewal — (permanent neonatal diabetes) only from a relevant specialist or nurse practitioner. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- Patient is continuing to derive benefit according to the treatment plan agreed at induction; and
- Patient remains fully compliant and transition to MDI is considered inappropriate by the treating physician; and
- It has been at least 4 years since the last insulin pump received by the patient or, in the case of patients qualifying under previous pump therapy for the initial application; the pump is due for replacement; and
- Either:

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

- 4.1 Applicant is a relevant specialist; or
- 4.2 Applicant is a nurse practitioner working within their vocational scope.

Initial application — (severe unexplained hypoglycaemia) only from a relevant specialist or nurse practitioner. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 Patient has type 1 diabetes or has undergone a pancreatectomy or has cystic fibrosis-related diabetes; and
- 2 Has undertaken carbohydrate counting education (either a carbohydrate counting course or direct education from an appropriate health professional); and
- 3 Applicant is part of a multidisciplinary team experienced in the management of type 1 diabetes care; and
- 4 Has adhered to an intensive MDI regimen using analogue insulins for at least six months; and
- 5 Has had four severe unexplained hypoglycaemic episodes over a six month period (severe as defined as requiring the assistance of another person); and
- 6 Has an average HbA1c between the following range: equal to or greater than 53 mmol/mol and equal to or less than 90 mmol/mol; and
- 7 Has been evaluated by the multidisciplinary team for their suitability for insulin pump therapy; and
- 8 Either:
 - 8.1 Applicant is a relevant specialist; or
 - 8.2 Applicant is a nurse practitioner working within their vocational scope.

Renewal — (severe unexplained hypoglycaemia) only from a relevant specialist or nurse practitioner. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 Patient is continuing to derive benefit according to the treatment plan agreed at induction of at least a 50% reduction from baseline in hypoglycaemic events; and
- 2 HbA1c has not increased by more than 5 mmol/mol from baseline; and
- 3 Either:
 - 3.1 It has been at least 4 years since the last insulin pump was received by the patient; or
 - 3.2 The pump is due for replacement; and
- 4 Either:
 - 4.1 Applicant is a relevant specialist; or
 - 4.2 Applicant is a nurse practitioner working within their vocational scope.

Initial application — (HbA1c) only from a relevant specialist or nurse practitioner. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 Patient has type 1 diabetes or has undergone a pancreatectomy or has cystic fibrosis-related diabetes; and
- 2 Has undertaken carbohydrate counting education (either a carbohydrate counting course or direct education from an appropriate health professional); and
- 3 Applicant is part of a multidisciplinary team experienced in the management of type 1 diabetes care; and
- 4 Has adhered to an intensive MDI regimen using analogue insulins for at least six months; and
- 5 Has unpredictable and significant variability in blood glucose including significant hypoglycaemia affecting the ability to reduce HbA1c; and
- 6 In the opinion of the treating clinician, HbA1c could be reduced by at least 10 mmol/mol using insulin pump treatment; and
- 7 Has typical HbA1c results between the following range: equal to or greater than 65 mmol/mol and equal to or less than 90 mmol/mol; and
- 8 Has been evaluated by the multidisciplinary team for their suitability for insulin pump therapy; and
- 9 Either:
 - 9.1 Applicant is a relevant specialist; or
 - 9.2 Applicant is a nurse practitioner working within their vocational scope.

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
---	-----	--------------------------	-------------------------------------

continued...

Renewal — (HbA1c) only from a relevant specialist or nurse practitioner. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 Patient is continuing to derive benefit according to the treatment plan agreed at induction of achieving and maintaining a reduction in HbA1c from baseline of 10 mmol/mol; and
- 2 The number of severe unexplained recurrent hypoglycaemic episodes has not increased from baseline; and
- 3 Either:
 - 3.1 It has been at least 4 years since the last insulin pump was received by the patient; or
 - 3.2 The pump is due for replacement; and
- 4 Either:
 - 4.1 Applicant is a relevant specialist; or
 - 4.2 Applicant is a nurse practitioner working within their vocational scope.

Initial application — (Previous use before 1 September 2012) only from a relevant specialist or nurse practitioner. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 Patient has type 1 diabetes or has undergone a pancreatectomy or has cystic fibrosis-related diabetes; and
- 2 Was already on pump treatment prior to 1 September 2012 and had been evaluated by the multidisciplinary team for their suitability for insulin pump therapy at the time of initiating that pump treatment and continues to benefit from pump treatment; and
- 3 The patient has adhered to an intensive MDI regimen using analogue insulins for at least six months prior to initiating pump therapy; and
- 4 The patient is continuing to derive benefit from pump therapy; and
- 5 The patient had achieved and is maintaining a HbA1c of equal to or less than 80 mmol/mol on pump therapy; and
- 6 The patient has had no increase in severe unexplained hypoglycaemic episodes from baseline; and
- 7 The patient's HbA1c has not deteriorated more than 5 mmol/mol from baseline; and
- 8 Either:
 - 8.1 It has been at least 4 years since the last insulin pump was received by the patient; or
 - 8.2 The pump is due for replacement; and
- 9 Either:
 - 9.1 Applicant is a relevant specialist; or
 - 9.2 Applicant is a nurse practitioner working within their vocational scope.

Renewal — (Previous use before 1 September 2012) only from a relevant specialist or nurse practitioner. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 The patient is continuing to derive benefit according to the treatment plan and has maintained a HbA1c of equal to or less than 80 mmol/mol; and
- 2 The patient's HbA1c has not deteriorated more than 5 mmol/mol from the time of commencing pump treatment; and
- 3 The patient has not had an increase in severe unexplained hypoglycaemic episodes from baseline; and
- 4 Either:
 - 4.1 It has been at least 4 years since the last insulin pump was received by the patient; or
 - 4.2 The pump is due for replacement; and
- 5 Either:
 - 5.1 Applicant is a relevant specialist; or
 - 5.2 Applicant is a nurse practitioner working within their vocational scope.

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

Insulin Pump Consumables

►SA1604 Special Authority for Subsidy

Initial application — (permanent neonatal diabetes) only from a relevant specialist or nurse practitioner. Approvals valid for 9 months for applications meeting the following criteria:

All of the following:

- 1 Patient has permanent neonatal diabetes; and
- 2 A MDI regimen trial is inappropriate; and
- 3 Has been evaluated by the multidisciplinary team for their suitability for insulin pump therapy; and
- 4 Patient/Parent/Guardian has undertaken carbohydrate counting education (either a carbohydrate counting course or direct education from an appropriate health professional); and
- 5 Applicant is part of a multidisciplinary team experienced in the management of type 1 diabetes care; and
- 6 Either:
 - 6.1 Applicant is a relevant specialist; or
 - 6.2 Applicant is a nurse practitioner working within their vocational scope.

Renewal — (permanent neonatal diabetes) only from a relevant specialist or nurse practitioner. Approvals valid for 2 years for applications meeting the following criteria:

All of the following:

- 1 Patient is continuing to derive benefit according to the treatment plan agreed at induction; and
- 2 Patient remains fully compliant and transition to MDI is considered inappropriate by the treating physician; and
- 3 Either:
 - 3.1 Applicant is a relevant specialist; or
 - 3.2 Applicant is a nurse practitioner working within their vocational scope.

Initial application — (severe unexplained hypoglycaemia) only from a relevant specialist or nurse practitioner. Approvals valid for 9 months for applications meeting the following criteria:

All of the following:

- 1 Patient has type 1 diabetes or has undergone a pancreatectomy or has cystic fibrosis-related diabetes; and
- 2 Has undertaken carbohydrate counting education (either a carbohydrate counting course or direct education from an appropriate health professional); and
- 3 Applicant is part of a multidisciplinary team experienced in the management of type 1 diabetes care; and
- 4 Has adhered to an intensive MDI regimen using analogue insulins for at least six months; and
- 5 Has had four severe unexplained hypoglycaemic episodes over a six month period (severe as defined as requiring the assistance of another person); and
- 6 Has an average HbA1c between the following range: equal to or greater than 53 mmol/mol and equal to or less than 90 mmol/mol; and
- 7 Has been evaluated by the multidisciplinary team for their suitability for insulin pump therapy; and
- 8 Either:
 - 8.1 Applicant is a relevant specialist; or
 - 8.2 Applicant is a nurse practitioner working within their vocational scope.

Renewal — (severe unexplained hypoglycaemia) only from a relevant specialist or nurse practitioner. Approvals valid for 2 years for applications meeting the following criteria:

All of the following:

- 1 Patient is continuing to derive benefit according to the treatment plan agreed at induction of at least a 50% reduction from baseline in hypoglycaemic events; and
- 2 HbA1c has not increased by more than 5 mmol/mol from baseline; and
- 3 Either:
 - 3.1 Applicant is a relevant specialist; or

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

3.2 Applicant is a nurse practitioner working within their vocational scope.

Initial application — (HbA1c) only from a relevant specialist or nurse practitioner. Approvals valid for 9 months for applications meeting the following criteria:

All of the following:

- 1 Patient has type 1 diabetes or has undergone a pancreatectomy or has cystic fibrosis-related diabetes; and
- 2 Has undertaken carbohydrate counting education (either a carbohydrate counting course or direct education from an appropriate health professional); and
- 3 Applicant is part of a multidisciplinary team experienced in the management of type 1 diabetes care; and
- 4 Has adhered to an intensive MDI regimen using analogue insulins for at least six months; and
- 5 Has unpredictable and significant variability in blood glucose including significant hypoglycaemia affecting the ability to reduce HbA1c; and
- 6 In the opinion of the treating clinician, HbA1c could be reduced by at least 10 mmol/mol using insulin pump treatment; and
- 7 Has typical HbA1c results between the following range: equal to or greater than 65 mmol/mol and equal to or less than 90 mmol/mol; and
- 8 Has been evaluated by the multidisciplinary team for their suitability for insulin pump therapy; and
- 9 Either:
 - 9.1 Applicant is a relevant specialist; or
 - 9.2 Applicant is a nurse practitioner working within their vocational scope.

Renewal — (HbA1c) only from a relevant specialist or nurse practitioner. Approvals valid for 2 years for applications meeting the following criteria:

All of the following:

- 1 Patient is continuing to derive benefit according to the treatment plan agreed at induction of achieving and maintaining a reduction in HbA1c from baseline of 10 mmol/mol; and
- 2 The number of severe unexplained recurrent hypoglycaemic episodes has not increased from baseline; and
- 3 Either:
 - 3.1 Applicant is a relevant specialist; or
 - 3.2 Applicant is a nurse practitioner working within their vocational scope.

Initial application — (Previous use before 1 September 2012) only from a relevant specialist or nurse practitioner. Approvals valid for 2 years for applications meeting the following criteria:

All of the following:

- 1 Patient has type 1 diabetes or has undergone a pancreatectomy or has cystic fibrosis-related diabetes; and
- 2 Was already on pump treatment prior to 1 September 2012 and had been evaluated by the multidisciplinary team for their suitability for insulin pump therapy at the time of initiating that pump treatment and continues to benefit from pump treatment; and
- 3 The patient has adhered to an intensive MDI regimen using analogue insulins for at least six months prior to initiating pump therapy; and
- 4 The patient is continuing to derive benefit from pump therapy; and
- 5 The patient had achieved and is maintaining a HbA1c of equal to or less than 80 mmol/mol on pump therapy; and
- 6 The patient has had no increase in severe unexplained hypoglycaemic episodes from baseline; and
- 7 The patient's HbA1c has not deteriorated more than 5 mmol/mol from baseline; and
- 8 Either:
 - 8.1 Applicant is a relevant specialist; or
 - 8.2 Applicant is a nurse practitioner working within their vocational scope.

Renewal — (Previous use before 1 September 2012) only from a relevant specialist or nurse practitioner. Approvals valid for 2 years for applications meeting the following criteria:

All of the following:

- 1 The patient is continuing to derive benefit according to the treatment plan and has maintained a HbA1c of equal to or less

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

- than 80 mmol/mol; and
- 2 The patient's HbA1c has not deteriorated more than 5 mmol/mol from initial application; and
- 3 The patient has not had an increase in severe unexplained hypoglycaemic episodes from baseline; and
- 4 Either:
 - 4.1 Applicant is a relevant specialist; or
 - 4.2 Applicant is a nurse practitioner working within their vocational scope.

INSULIN PUMP ACCESSORIES – Special Authority see [SA1604 on page 17](#) – Retail pharmacy

- a) Maximum of 1 cap per prescription
- b) Only on a prescription
- c) Maximum of 1 prescription per 180 days.

Battery cap 32.00 1 ✓ **Animas Battery Cap**

(Animas Battery Cap Battery cap to be delisted 1 October 2019)

INSULIN PUMP CARTRIDGE – Special Authority see [SA1604 on page 17](#) – Retail pharmacy

- a) Maximum of 3 sets per prescription
- b) Only on a prescription
- c) Maximum of 13 packs of cartridge sets will be funded per year.

Cartridge 300 U, t:lock x 10 50.00 1 OP ✓ **Tandem Cartridge**

ALIMENTARY TRACT AND METABOLISM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
INSULIN PUMP INFUSION SET (STEEL CANNULA) – Special Authority see SA1604 on page 17 – Retail pharmacy				
a) Maximum of 3 sets per prescription				
b) Only on a prescription				
c) Maximum of 13 infusion sets will be funded per year.				
10 mm steel needle; 29 G; manual insertion; 60 cm tubing x 10 with 10 needles.....	130.00	1 OP	✓	Paradigm Sure-T MMT-884
10 mm steel needle; 29 G; manual insertion; 60 cm tubing x 10 with 10 needles; luer lock	130.00	1 OP	✓	Sure-T MMT-883
10 mm steel needle; 29 G; manual insertion; 80 cm tubing x 10 with 10 needles.....	130.00	1 OP	✓	Paradigm Sure-T MMT-886
10 mm steel needle; 29 G; manual insertion; 80 cm tubing x 10 with 10 needles; luer lock	130.00	1 OP	✓	Sure-T MMT-885
6 mm steel cannula; straight insertion; 60 cm grey line x 10 with 10 needles	130.00	1 OP	✓	Contact-D
6 mm steel needle; 29 G; manual insertion; 60 cm tubing x 10 with 10 needles.....	130.00	1 OP	✓	Paradigm Sure-T MMT-864
6 mm steel needle; 29 G; manual insertion; 60 cm tubing x 10 with 10 needles; luer lock	130.00	1 OP	✓	Sure-T MMT-863
6 mm steel needle; 29 G; manual insertion; 80 cm tubing x 10 with 10 needles.....	130.00	1 OP	✓	Paradigm Sure-T MMT-866
6 mm steel needle; 29 G; manual insertion; 80 cm tubing x 10 with 10 needles; luer lock	130.00	1 OP	✓	Sure-T MMT-865
8 mm steel cannula; straight insertion; 110 cm grey line x 10 with 10 needles.....	130.00	1 OP	✓	Contact-D
8 mm steel cannula; straight insertion; 60 cm grey line x 10 with 10 needles	130.00	1 OP	✓	Contact-D
8 mm steel needle; 29 G; manual insertion; 60 cm tubing x 10 with 10 needles.....	130.00	1 OP	✓	Paradigm Sure-T MMT-874
8 mm steel needle; 29 G; manual insertion; 60 cm tubing x 10 with 10 needles; luer lock	130.00	1 OP	✓	Sure-T MMT-873
8 mm steel needle; 29 G; manual insertion; 80 cm tubing x 10 with 10 needles.....	130.00	1 OP	✓	Paradigm Sure-T MMT-876
8 mm steel needle; 29 G; manual insertion; 80 cm tubing x 10 with 10 needles; luer lock	130.00	1 OP	✓	Sure-T MMT-875

(Contact-D 6 mm steel cannula; straight insertion; 60 cm grey line x 10 with 10 needles to be delisted 1 October 2019)
 (Contact-D 8 mm steel cannula; straight insertion; 110 cm grey line x 10 with 10 needles to be delisted 1 October 2019)
 (Contact-D 8 mm steel cannula; straight insertion; 60 cm grey line x 10 with 10 needles to be delisted 1 October 2019)

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
INSULIN PUMP INFUSION SET (STEEL CANNULA, STRAIGHT INSERTION) – Special Authority see SA1604 on page 17 – Retail pharmacy			
a) Maximum of 3 sets per prescription			
b) Only on a prescription			
c) Maximum of 13 infusion sets will be funded per year.			
6 mm steel cannula; straight insertion; 60 cm line x 10 with 10 needles.....	130.00	1 OP	✓ TruSteel
6 mm steel cannula; straight insertion; 81 cm line x 10 with 10 needles.....	130.00	1 OP	✓ TruSteel
8 mm steel cannula; straight insertion; 60 cm line x 10 with 10 needles.....	130.00	1 OP	✓ TruSteel
8 mm steel cannula; straight insertion; 81 cm line x 10 with 10 needles.....	130.00	1 OP	✓ TruSteel
INSULIN PUMP INFUSION SET (TEFLON CANNULA, ANGLE INSERTION WITH INSERTION DEVICE) – Special Authority see SA1604 on page 17 – Retail pharmacy			
a) Maximum of 3 sets per prescription			
b) Only on a prescription			
c) Maximum of 13 infusion sets will be funded per year.			
13 mm teflon cannula; angle insertion; insertion device; 110 cm grey line x 10 with 10 needles.....	140.00	1 OP	✓ Inset 30
13 mm teflon cannula; angle insertion; insertion device; 60 cm grey line x 10 with 10 needles.....	140.00	1 OP	✓ Inset 30
13 mm teflon cannula; angle insertion; insertion device; 110 cm line x 10 with 10 needles.....	140.00	1 OP	✓ AutoSoft 30
13 mm teflon cannula; angle insertion; insertion device; 60 cm line x 10 with 10 needles.....	140.00	1 OP	✓ AutoSoft 30
<i>(Inset 30 13 mm teflon cannula; angle insertion; insertion device; 110 cm grey line x 10 with 10 needles to be delisted 1 October 2019)</i>			
<i>(Inset 30 13 mm teflon cannula; angle insertion; insertion device; 60 cm grey line x 10 with 10 needles to be delisted 1 October 2019)</i>			

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
INSULIN PUMP INFUSION SET (TEFLON CANNULA, ANGLE INSERTION) – Special Authority see SA1604 on page 17 – Retail pharmacy				
a) Maximum of 3 sets per prescription				
b) Only on a prescription				
c) Maximum of 13 infusion sets will be funded per year.				
13 mm teflon cannula; angle insertion; 120 cm line x 10 with 10 needles.....	130.00	1 OP	✓	Paradigm Silhouette MMT-382
13 mm teflon cannula; angle insertion; 45 cm line x 10 with 10 needles.....	130.00	1 OP	✓	Paradigm Silhouette MMT-368
13 mm teflon cannula; angle insertion; 60 cm line x 10 with 10 needles.....	130.00	1 OP	✓	Paradigm Silhouette MMT-381
13 mm teflon cannula; angle insertion; 80 cm line x 10 with 10 needles.....	130.00	1 OP	✓	Paradigm Silhouette MMT-383
17 mm teflon cannula; angle insertion; 110 cm line x 10 with 10 needles.....	130.00	1 OP	✓	Paradigm Silhouette MMT-377
17 mm teflon cannula; angle insertion; 110 cm line x 10 with 10 needles; luer lock.....	130.00	1 OP	✓	Silhouette MMT-371
17 mm teflon cannula; angle insertion; 60 cm line x 10 with 10 needles.....	130.00	1 OP	✓	Paradigm Silhouette MMT-378
17 mm teflon cannula; angle insertion; 60 cm line x 10 with 10 needles; luer lock.....	130.00	1 OP	✓	Silhouette MMT-373
17 mm teflon cannula; angle insertion; 80 cm line x 10 with 10 needles.....	130.00	1 OP	✓	Paradigm Silhouette MMT-384

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
INSULIN PUMP INFUSION SET (TEFLON CANNULA, STRAIGHT INSERTION WITH INSERTION DEVICE) – Special Authority see SA1604 on page 17 – Retail pharmacy			
a) Maximum of 3 sets per prescription			
b) Only on a prescription			
c) Maximum of 13 infusion sets will be funded per year.			
6 mm teflon cannula; straight insertion; insertion device; 110 cm grey line x 10 with 10 needles	140.00	1 OP	✓ Inset II
6 mm teflon cannula; straight insertion; insertion device; 45 cm blue tubing x 10 with 10 needles	130.00	1 OP	✓ Paradigm Mio MMT-941
6 mm teflon cannula; straight insertion; insertion device; 45 cm pink tubing x 10 with 10 needles	130.00	1 OP	✓ Paradigm Mio MMT-921
6 mm teflon cannula; straight insertion; insertion device; 60 cm blue tubing x 10 with 10 needles	130.00	1 OP	✓ Paradigm Mio MMT-943
6 mm teflon cannula; straight insertion; insertion device; 60 cm grey line x 10 with 10 needles	140.00	1 OP	✓ Inset II
6 mm teflon cannula; straight insertion; insertion device; 60 cm pink tubing x 10 with 10 needles	130.00	1 OP	✓ Paradigm Mio MMT-923
6 mm teflon cannula; straight insertion; insertion device; 80 cm blue tubing x 10 with 10 needles	130.00	1 OP	✓ Paradigm Mio MMT-945
6 mm teflon cannula; straight insertion; insertion device; 80 cm clear tubing x 10 with 10 needles	130.00	1 OP	✓ Paradigm Mio MMT-965
6 mm teflon cannula; straight insertion; insertion device; 80 cm pink tubing x 10 with 10 needles	130.00	1 OP	✓ Paradigm Mio MMT-925
9 mm teflon cannula; straight insertion; insertion device; 110 cm grey line x 10 with 10 needles	140.00	1 OP	✓ Inset II
9 mm teflon cannula; straight insertion; insertion device; 60 cm grey line x 10 with 10 needles	140.00	1 OP	✓ Inset II
9 mm teflon cannula; straight insertion; insertion device; 80 cm clear tubing x 10 with 10 needles	130.00	1 OP	✓ Paradigm Mio MMT-975
6 mm teflon cannula; straight insertion; insertion device; 110 cm line x 10 with 10 needles	140.00	1 OP	✓ AutoSoft 90
6 mm teflon cannula; straight insertion; insertion device; 60 cm line x 10 with 10 needles	140.00	1 OP	✓ AutoSoft 90
9 mm teflon cannula; straight insertion; insertion device; 110 cm line x 10 with 10 needles	140.00	1 OP	✓ AutoSoft 90

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

ALIMENTARY TRACT AND METABOLISM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
9 mm teflon cannula; straight insertion; insertion device; 60 cm line × 10 with 10 needles.....	140.00	1 OP	✓	AutoSoft 90
<i>(Inset II 6 mm teflon cannula; straight insertion; insertion device; 110 cm grey line × 10 with 10 needles to be delisted 1 October 2019)</i>				
<i>(Inset II 6 mm teflon cannula; straight insertion; insertion device; 60 cm grey line × 10 with 10 needles to be delisted 1 October 2019)</i>				
<i>(Inset II 9 mm teflon cannula; straight insertion; insertion device; 110 cm grey line × 10 with 10 needles to be delisted 1 October 2019)</i>				
<i>(Inset II 9 mm teflon cannula; straight insertion; insertion device; 60 cm grey line × 10 with 10 needles to be delisted 1 October 2019)</i>				
INSULIN PUMP INFUSION SET (TEFLON CANNULA, STRAIGHT INSERTION) – Special Authority see SA1604 on page 17 – Retail pharmacy				
a) Maximum of 3 sets per prescription				
b) Only on a prescription				
c) Maximum of 13 infusion sets will be funded per year.				
6 mm teflon cannula; straight insertion; 110 cm tubing × 10 with 10 needles.....	130.00	1 OP	✓	Paradigm Quick-Set MMT-398
6 mm teflon cannula; straight insertion; 110 cm tubing × 10 with 10 needles; luer lock.....	130.00	1 OP	✓	Quick-Set MMT-391
6 mm teflon cannula; straight insertion; 60 cm tubing × 10 with 10 needles.....	130.00	1 OP	✓	Paradigm Quick-Set MMT-399
6 mm teflon cannula; straight insertion; 60 cm tubing × 10 with 10 needles; luer lock.....	130.00	1 OP	✓	Quick-Set MMT-393
6 mm teflon cannula; straight insertion; 80 cm tubing × 10 with 10 needles.....	130.00	1 OP	✓	Paradigm Quick-Set MMT-387
9 mm teflon cannula; straight insertion; 106 cm tubing × 10 with 10 needles.....	130.00	1 OP	✓	Paradigm Quick-Set MMT-396
9 mm teflon cannula; straight insertion; 110 cm tubing × 10 with 10 needles; luer lock.....	130.00	1 OP	✓	Quick-Set MMT-390
9 mm teflon cannula; straight insertion; 60 cm tubing × 10 with 10 needles.....	130.00	1 OP	✓	Paradigm Quick-Set MMT-397
9 mm teflon cannula; straight insertion; 60 cm tubing × 10 with 10 needles; luer lock.....	130.00	1 OP	✓	Quick-Set MMT-392
9 mm teflon cannula; straight insertion; 80 cm tubing × 10 with 10 needles.....	130.00	1 OP	✓	Paradigm Quick-Set MMT-386

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
INSULIN PUMP RESERVOIR – Special Authority see SA1604 on page 17 – Retail pharmacy			
a) Maximum of 3 sets per prescription			
b) Only on a prescription			
c) Maximum of 13 packs of reservoir sets will be funded per year.			
10 x luer lock conversion cartridges 1.8 ml for Paradigm pumps.....	50.00	1 OP	✓ ADR Cartridge 1.8
Cartridge 200 U, luer lock x 10.....	50.00	1 OP	✓ Animas Cartridge
Cartridge for 5 and 7 series pump; 1.8 ml x 10	50.00	1 OP	✓ Paradigm 1.8 Reservoir
Cartridge for 7 series pump; 3.0 ml x 10	50.00	1 OP	✓ Paradigm 3.0 Reservoir
Syringe and cartridge for 50X pump, 3.0 ml x 10	50.00	1 OP	✓ 50X 3.0 Reservoir
<i>(Animas Cartridge Cartridge 200 U, luer lock x 10 to be delisted 1 October 2019)</i>			
<i>(50X 3.0 Reservoir Syringe and cartridge for 50X pump, 3.0 ml x 10 to be delisted 1 October 2019)</i>			

Digestives Including Enzymes

PANCREATIC ENZYME

Cap pancreatin 150 mg (amylase 8,000 Ph Eur U, lipase 10,000 Ph Eur U, total protease 600 Ph Eur U)	34.93	100	✓ Creon 10000
Cap pancreatin (175 mg (25,000 U lipase, 22,500 U amylase, 1,250 U protease))	94.40	100	✓ Panzytrat
Cap pancreatin 300 mg (amylase 18,000 Ph Eur U, lipase 25,000 Ph Eur U, total protease 1,000 Ph Eur U)	94.38	100	✓ Creon 25000
URSODEOXYCHOLIC ACID – Special Authority see SA1739 below – Retail pharmacy			
Cap 250 mg	37.95	100	✓ Ursosan

►SA1739 Special Authority for Subsidy

Initial application — (Alagille syndrome or progressive familial intrahepatic cholestasis) from any relevant practitioner.

Approvals valid without further renewal unless notified for applications meeting the following criteria:

Either:

- 1 Patient has been diagnosed with Alagille syndrome; or
- 2 Patient has progressive familial intrahepatic cholestasis.

Initial application — (Chronic severe drug induced cholestatic liver injury) from any relevant practitioner. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 Patient has chronic severe drug induced cholestatic liver injury; and
- 2 Cholestatic liver injury not due to Total Parenteral Nutrition (TPN) use in adults; and
- 3 Treatment with ursodeoxycholic acid may prevent hospital admission or reduce duration of stay.

Initial application — (Primary biliary cholangitis) from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Primary biliary cholangitis confirmed by antimitochondrial antibody titre (AMA) > 1:80, and raised cholestatic liver enzymes with or without raised serum IgM or, if AMA is negative, by liver biopsy; and
- 2 Patient not requiring a liver transplant (bilirubin > 100 µmol/l; decompensated cirrhosis).

Initial application — (Pregnancy) from any relevant practitioner. Approvals valid for 6 months where the patient diagnosed with cholestasis of pregnancy.

Initial application — (Haematological Transplant) from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

continued...

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

- 1 Patient at risk of veno-occlusive disease or has hepatic impairment and is undergoing conditioning treatment prior to allogeneic stem cell or bone marrow transplantation; and
- 2 Treatment for up to 13 weeks.

Initial application — (Total parenteral nutrition induced cholestasis) from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Paediatric patient has developed abnormal liver function as indicated on testing which is likely to be induced by Total Parenteral Nutrition (TPN); and
- 2 Liver function has not improved with modifying the TPN composition.

Renewal — (Chronic severe drug induced cholestatic liver injury) from any relevant practitioner. Approvals valid for 6 months where the patient continues to benefit from treatment.

Renewal — (Pregnancy/Primary biliary cholangitis) from any relevant practitioner. Approvals valid for 2 years where the treatment remains appropriate and the patient is benefiting from treatment.

Renewal — (Total parenteral nutrition induced cholestasis) from any relevant practitioner. Approvals valid for 6 months where the paediatric patient continues to require TPN and who is benefiting from treatment, defined as a sustained improvement in bilirubin levels.

Note: Ursodeoxycholic acid is not an appropriate therapy for patients requiring a liver transplant (bilirubin > 100 micromol/l; decompensated cirrhosis). These patients should be referred to an appropriate transplant centre. Treatment failure -- doubling of serum bilirubin levels, absence of a significant decrease in ALP or ALT and AST, development of varices, ascites or encephalopathy, marked worsening of pruritus or fatigue, histological progression by two stages, or to cirrhosis, need for transplantation.

Laxatives

Bulk-forming Agents

ISPAGHULA (PSYLLIUM) HUSK – Only on a prescription

* Powder for oral soln.....	6.05	500 g OP	✓ Bonvit ✓ Konsyl-D
-----------------------------	------	----------	--------------------------------------

MUCILAGINOUS LAXATIVES WITH STIMULANTS

* Dry.....	6.02 (17.32) 2.41 (8.72)	500 g OP 200 g OP	 Normacol Plus Normacol Plus
------------	-----------------------------------	--------------------------	--

Faecal Softeners

DOCUSATE SODIUM – Only on a prescription

* Tab 50 mg	2.31	100	✓ Coloxyl
* Tab 120 mg	3.13	100	✓ Coloxyl
* Enema conc 18%	5.40	100 ml OP	✓ Coloxyl

(Coloxyl Enema conc 18% to be delisted 1 April 2019)

DOCUSATE SODIUM WITH SENNOSIDES

* Tab 50 mg with sennosides 8 mg.....	3.10	200	✓ Laxsol
---------------------------------------	------	-----	-----------------

POLOXAMER – Only on a prescription

Not funded for use in the ear.

* Oral drops 10%.....	3.78	30 ml OP	✓ Coloxyl
-----------------------	------	----------	------------------

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
---	----------------------------	-------------------------------------

Opioid Receptor Antagonists - Peripheral

METHYLNALTREXONE BROMIDE – Special Authority see [SA1691 below](#) – Retail pharmacy

Inj 12 mg per 0.6 ml vial	36.00	1	✓ Relistor
	246.00	7	✓ Relistor

►SA1691 Special Authority for Subsidy

Initial application — (Opioid induced constipation) from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- 1 The patient is receiving palliative care; and
- 2 Either:
 - 2.1 Oral and rectal treatments for opioid induced constipation are ineffective; or
 - 2.2 Oral and rectal treatments for opioid induced constipation are unable to be tolerated.

Osmotic Laxatives

GLYCEROL

* Suppos 3.6 g – Only on a prescription9.25 20 ✓ **PSM**

LACTULOSE – Only on a prescription

* Oral liq 10 g per 15 ml3.18 500 ml ✓ **Laevolac**

MACROGOL 3350 WITH POTASSIUM CHLORIDE, SODIUM BICARBONATE AND SODIUM CHLORIDE

Powder for oral soln 13.125 g with potassium chloride 46.6 mg,
sodium bicarbonate 178.5 mg and sodium chloride 350.7 mg6.78 30 ✓ **Molaxole**

SODIUM ACID PHOSPHATE – Only on a prescription

Enema 16% with sodium phosphate 8%2.50 1 ✓ **Fleet Phosphate Enema**

SODIUM CITRATE WITH SODIUM LAURYL SULPHOACETATE – Only on a prescription

Enema 90 mg with sodium lauryl sulphoacetate 9 mg per ml,
5 ml26.72 50 ✓ **Micolette**

Stimulant Laxatives

BISACODYL – Only on a prescription

* Tab 5 mg5.99 200 ✓ **Lax-Tab**

* Suppos 10 mg3.74 10 ✓ **Lax-Suppositories**

SENNA – Only on a prescription

* Tab, standardised.....	2.17	100	
	(6.84)		Senokot
	0.43	20	
	(1.72)		Senokot

Metabolic Disorder Agents

ALGLUCOSIDASE ALFA – Special Authority see [SA1622 on the next page](#) – Retail pharmacy

Inj 50 mg vial1,142.60 1 ✓ **Myozyme**

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
	✓	

►SA1622 Special Authority for Subsidy

Initial application only from a metabolic physician. Approvals valid for 12 months for applications meeting the following criteria:
All of the following:

- 1 The patient is aged up to 24 months at the time of initial application and has been diagnosed with infantile Pompe disease; and
- 2 Any of the following:
 - 2.1 Diagnosis confirmed by documented deficiency of acid alpha-glucosidase by prenatal diagnosis using chorionic villus biopsies and/or cultured amniotic cells; or
 - 2.2 Documented deficiency of acid alpha-glucosidase, and urinary tetrasaccharide testing indicating a diagnostic elevation of glucose tetrasaccharides; or
 - 2.3 Documented deficiency of acid alpha-glucosidase, and documented molecular genetic testing indicating a disease-causing mutation in the acid alpha-glucosidase gene (GAA gene); or
 - 2.4 Documented urinary tetrasaccharide testing indicating a diagnostic elevation of glucose tetrasaccharides, and molecular genetic testing indicating a disease-causing mutation in the GAA gene; and
- 3 Patient has not required long-term invasive ventilation for respiratory failure prior to starting enzyme replacement therapy (ERT); and
- 4 Patient does not have another life-threatening or severe disease where the prognosis is unlikely to be influenced by ERT or might be reasonably expected to compromise a response to ERT; and
- 5 Alglucosidase alfa to be administered at doses no greater than 20 mg/kg every 2 weeks.

Renewal only from a metabolic physician. Approvals valid for 12 months for applications meeting the following criteria:
All of the following:

- 1 The treatment remains appropriate for the patient and the patient is benefiting from treatment; and
- 2 Alglucosidase alfa to be administered at doses no greater than 20 mg/kg every 2 weeks; and
- 3 Patient has not had severe infusion-related adverse reactions which were not preventable by appropriate pre-medication and/or adjustment of infusion rates; and
- 4 Patient has not developed another life threatening or severe disease where the long term prognosis is unlikely to be influenced by ERT; and
- 5 Patient has not developed another medical condition that might reasonably be expected to compromise a response to ERT; and
- 6 There is no evidence of life threatening progression of respiratory disease as evidenced by the needed for > 14 days of invasive ventilation; and
- 7 There is no evidence of new or progressive cardiomyopathy.

BETAINE – Special Authority see [SA1727 below](#) – Retail pharmacy

Powder for oral soln.....	575.00	180 g OP	✓ Cystadane
---------------------------	--------	----------	-------------

►SA1727 Special Authority for Subsidy

Initial application only from a metabolic physician. Approvals valid for 12 months for applications meeting the following criteria:
All of the following:

- 1 The patient has a confirmed diagnosis of homocystinuria; and
- 2 Any of the following:
 - 2.1 A cystathionine beta-synthase (CBS) deficiency; or
 - 2.2 A 5,10-methylene-tetrahydrofolate reductase (MTHFR) deficiency; or
 - 2.3 A disorder of intracellular cobalamin metabolism; and
- 3 An appropriate homocysteine level has not been achieved despite a sufficient trial of appropriate vitamin supplementation.

Renewal only from a metabolic physician. Approvals valid for 12 months where the treatment remains appropriate and the patient is benefiting from treatment.

GALSULFASE – Special Authority see [SA1593 on the next page](#) – Retail pharmacy

Inj 1 mg per ml, 5 ml vial.....	2,234.00	1	✓ Naglazyme
---------------------------------	----------	---	-------------

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

► **SA1593** **Special Authority for Subsidy**

Initial application only from a metabolic physician. Approvals valid for 12 months for applications meeting the following criteria:
Both:

- 1 The patient has been diagnosed with mucopolysaccharidosis VI; and
- 2 Either:
 - 2.1 Diagnosis confirmed by demonstration of N-acetyl-galactosamine-4-sulfatase (arylsulfatase B) deficiency by either enzyme activity assay in leukocytes or skin fibroblasts; or
 - 2.2 Detection of two disease causing mutations and patient has a sibling who is known to have mucopolysaccharidosis VI.

Renewal only from a metabolic physician. Approvals valid for 12 months for applications meeting the following criteria:
All of the following:

- 1 The treatment remains appropriate for the patient and the patient is benefiting from treatment; and
- 2 Patient has not had severe infusion-related adverse reactions which were not preventable by appropriate pre-medication and/or adjustment of infusion rates; and
- 3 Patient has not developed another life threatening or severe disease where the long term prognosis is unlikely to be influenced by Enzyme Replacement Therapy (ERT); and
- 4 Patient has not developed another medical condition that might reasonably be expected to compromise a response to ERT.

IDURSULFASE – Special Authority see [SA1623 below](#) – Retail pharmacy

Inj 2 mg per ml, 3 ml vial.....	4,608.30	1	✓ Elaprase
---------------------------------	----------	---	-------------------

► **SA1623** **Special Authority for Subsidy**

Initial application only from a metabolic physician. Approvals valid for 24 weeks for applications meeting the following criteria:
All of the following:

- 1 The patient has been diagnosed with Hunter Syndrome (mucopolysaccharidosis II); and
- 2 Either:
 - 2.1 Diagnosis confirmed by demonstration of iduronate 2-sulfatase deficiency in white blood cells by either enzyme assay in cultured skin fibroblasts; or
 - 2.2 Detection of a disease causing mutation in the iduronate 2-sulfatase gene; and
- 3 Patient is going to proceed with a haematopoietic stem cell transplant (HSCT) within the next 3 months and treatment with idursulfase would be bridging treatment to transplant; and
- 4 Patient has not required long-term invasive ventilation for respiratory failure prior to starting Enzyme Replacement Therapy (ERT); and
- 5 Idursulfase to be administered for a total of 24 weeks (equivalent to 12 weeks pre- and 12 weeks post-HSCT) at doses no greater than 0.5 mg/kg every week.

LARONIDASE – Special Authority see [SA1695 below](#) – Retail pharmacy

Inj 100 U per ml, 5 ml vial.....	1,335.16	1	✓ Aldurazyme
----------------------------------	----------	---	---------------------

► **SA1695** **Special Authority for Subsidy**

Initial application only from a metabolic physician. Approvals valid for 24 weeks for applications meeting the following criteria:
All of the following:

- 1 The patient has been diagnosed with Hurler Syndrome (mucopolysaccharidosis I-H); and
- 2 Either:
 - 2.1 Diagnosis confirmed by demonstration of alpha-L-iduronidase deficiency in white blood cells by either enzyme assay in cultured skin fibroblasts; or
 - 2.2 Detection of two disease causing mutations in the alpha-L-iduronidase gene and patient has a sibling who is known to have Hurler syndrome; and
- 3 Patient is going to proceed with a haematopoietic stem cell transplant (HSCT) within the next 3 months and treatment with

continued...

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

- laronidase would be bridging treatment to transplant; and
- 4 Patient has not required long-term invasive ventilation for respiratory failure prior to starting Enzyme Replacement Therapy (ERT); and
- 5 Laronidase to be administered for a total of 24 weeks (equivalent to 12 weeks pre- and 12 post-HSCT) at doses no greater than 100 units/kg every week.

SAPROPTERIN DIHYDROCHLORIDE – Special Authority see [SA1757 below](#) – Retail pharmacy

Tab soluble 100 mg 1,452.70 30 OP ✓ **Kuvan**

► **SA1757** Special Authority for Subsidy

Initial application only from a metabolic physician. Approvals valid for 1 month for applications meeting the following criteria:

All of the following:

- 1 Patient has phenylketonuria (PKU) and is pregnant or actively planning to become pregnant; and
- 2 Treatment with sapropterin is required to support management of PKU during pregnancy; and
- 3 Sapropterin to be administered at doses no greater than a total daily dose of 20 mg/kg; and
- 4 Sapropterin to be used alone or in combination with PKU dietary management; and
- 5 Total treatment duration with sapropterin will not exceed 22 months for each pregnancy (includes time for planning and becoming pregnant) and treatment will be stopped after delivery.

Renewal only from a metabolic physician or any relevant practitioner on the recommendation of a metabolic physician.

Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Either:
 - 1.1 Following the initial one-month approval, the patient has demonstrated an adequate response to a 2 to 4 week trial of sapropterin with a clinically appropriate reduction in phenylalanine levels to support management of PKU during pregnancy; or
 - 1.2 On subsequent renewal applications, the patient has previously demonstrated response to treatment with sapropterin and maintained adequate phenylalanine levels to support management of PKU during pregnancy; and
- 2 Any of the following:
 - 2.1 Patient continues to be pregnant and treatment with sapropterin will not continue after delivery; or
 - 2.2 Patient is actively planning a pregnancy and this is the first renewal for treatment with sapropterin; or
 - 2.3 Treatment with sapropterin is required for a second or subsequent pregnancy to support management of their PKU during pregnancy; and
- 3 Sapropterin to be administered at doses no greater than a total daily dose of 20 mg/kg; and
- 4 Sapropterin to be used alone or in combination with PKU dietary management; and
- 5 Total treatment duration with sapropterin will not exceed 22 months for each pregnancy (includes time for planning and becoming pregnant) and treatment will be stopped after delivery.

SODIUM BENZOATE – Special Authority see [SA1599 below](#) – Retail pharmacy

Soln 100 mg per ml CBS 100 ml ✓ **Amzoate** \$29

► **SA1599** Special Authority for Subsidy

Initial application only from a metabolic physician. Approvals valid for 12 months where the patient has a diagnosis of a urea cycle disorder.

Renewal only from a metabolic physician. Approvals valid for 12 months where the treatment remains appropriate and the patient is benefiting from treatment.

SODIUM PHENYLBUTYRATE – Special Authority see [SA1598 on the next page](#) – Retail pharmacy

Grans 483 mg per g 1,920.00 174 g OP ✓ **Pheburane**

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
	✓	

►SA1598 Special Authority for Subsidy

Initial application only from a metabolic physician. Approvals valid for 12 months where the patient has a diagnosis of a urea cycle disorder involving a deficiency of carbamylphosphate synthetase, ornithine transcarbamylase or argininosuccinate synthetase.

Renewal only from a metabolic physician. Approvals valid for 12 months where the treatment remains appropriate and the patient is benefiting from treatment.

Gaucher's Disease

IMIGLUCERASE – Special Authority see [SA0473 below](#) – Retail pharmacy

Inj 40 iu per ml, 200 iu vial.....	1,072.00	1	✓ Cerezyme
Inj 40 iu per ml, 400 iu vial.....	2,144.00	1	✓ Cerezyme

(Cerezyme Inj 40 iu per ml, 200 iu vial to be delisted 1 March 2019)

(Cerezyme Inj 40 iu per ml, 400 iu vial to be delisted 1 March 2019)

►SA0473 Special Authority for Subsidy

Special Authority approved by the Gaucher's Treatment Panel

Notes: Subject to a budgetary cap. Applications will be considered and approved subject to funding availability.

Application details may be obtained from PHARMAC's website <http://www.pharmac.govt.nz> or:

The Co-ordinator, Gaucher's Treatment Panel Phone: (04) 460 4990
 PHARMAC, PO Box 10 254 Facsimile: (04) 916 7571
 Wellington Email: gaucherpanel@pharmac.govt.nz

TALIGLUCERASE ALFA – Special Authority see [SA1734 below](#) – Retail pharmacy

Inj 200 unit vial.....	1,072.00	1	✓ Elelyso
------------------------	----------	---	-----------

►SA1734 Special Authority for Subsidy

Special Authority approved by the Gaucher's Treatment Panel

Notes: Application details may be obtained from PHARMAC's website <http://www.pharmac.govt.nz> or:

The Co-ordinator, Gaucher's Treatment Panel Phone: 04 460 4990
 PHARMAC PO Box 10 254 Facsimile: 04 916 7571
 Wellington Email: gaucherpanel@pharmac.govt.nz

Completed application forms must be sent to the coordinator for Gaucher's Treatment Panel and will be considered by Gaucher's Treatment Panel at the next practicable opportunity.

Notification of Gaucher's Treatment Panel's decision will be sent to the patient, the applying clinician and the patient's GP (if specified).

Access Criteria

Initial application from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria: All of the following:

- 1) The patient has a diagnosis of symptomatic type 1 or type 3* Gaucher disease confirmed by the demonstration of specific deficiency of glucocerebrosidase in leukocytes or cultured skin fibroblasts, and genotypic analysis; and
- 2) Patient does not have another life-threatening or severe disease where the prognosis is unlikely to be influenced by taliglucerase alfa or might be reasonably expected to compromise a response to therapy with taliglucerase alfa; and
- 3) Taliglucerase alfa is to be administered at a dose no greater than 30 unit/kg every other week rounded to the nearest whole vial (200 units), unless otherwise agreed by PHARMAC; and
- 4) Supporting clinical information including test reports, MRI whole body STIR, serum glucosylsphingosine, haematological data, and other relevant investigations, are submitted to the Gaucher Panel for assessment; and
- 5) Any of the following:

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

- 6) 1) Patient has haematological complications such as haemoglobin less than 95 g/l, symptomatic anaemia, thrombocytopenia; at least two episodes of severely symptomatic splenic infarcts confirmed with imagery; or massive symptomatic splenomegaly; or
- 2) Patient has skeletal complications such as acute bone crisis requiring hospitalisation or major pain management strategies; radiological MRI Evidence of incipient destruction of any major joint (e.g. hips or shoulder); spontaneous fractures or vertebral collapse; chronic bone pain not controlled by other pharmaceuticals; or
- 3) Patient has significant liver dysfunction or hepatomegaly attributable to Gaucher disease; or
- 4) Patient has reduced vital capacity from clinically significant or progressive pulmonary disease due to Gaucher disease; or
- 5) Patient is a child and has experienced growth failure with significant decrease in percentile linear growth over a 6-12 month period.

*Unapproved indication

Renewal from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1) Patient has demonstrated a symptomatic improvement or no deterioration in the main symptom for which therapy was initiated; and
- 2) Patient has demonstrated a clinically objective improvement or no deterioration in haemoglobin levels, platelet counts and liver and spleen size; and
- 3) Radiological (MRI) signs of bone activity performed at one year and two years since initiation of treatment begins, and two to three yearly thereafter, demonstrate no deterioration shown by the MRI, compared with MRI taken immediately prior to commencement of therapy or adjusted dose; and
- 4) Serum glucosylsphingosine levels taken at least 6 to 12 monthly show a decrease compared with baseline; and
- 5) Patient has not had severe infusion-related adverse reactions which were not preventable by appropriate pre-medication and/or adjustment of infusion rates; and
- 6) Patient has not developed another medical condition that might reasonably be expected to compromise a response to ERT; and
- 7) Patient is compliant with regular treatment and taliglucerase alfa is to be administered at a dose no greater than 30 unit/kg every other week rounded to the nearest whole vial (200 units), unless otherwise agreed by PHARMAC; and
- 8) Supporting clinical information including test reports, MRI whole body STIR, serum glucosylsphingosine, haematological data, and other relevant investigations are submitted to the Gaucher Panel for assessment as required.

Mouth and Throat

Agents Used in Mouth Ulceration

BENZYDAMINE HYDROCHLORIDE

Soln 0.15% – Higher subsidy of up to \$17.01 per 500 ml with

Endorsement	9.00	500 ml	
	(17.01)		Difflam
	3.60	200 ml	
	(8.50)		Difflam

Additional subsidy by endorsement for a patient who has oral mucositis as a result of treatment for cancer, and the prescription is endorsed accordingly.

CARMELLOSE SODIUM WITH GELATIN AND PECTIN

Paste	17.20	56 g OP	✓ Stomahesive
	4.55	15 g OP	
	(7.90)		Orabase
	1.52	5 g OP	
	(3.60)		Orabase
Powder	8.48	28 g OP	
	(10.95)		Stomahesive

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
CHLORHEXIDINE GLUCONATE				
Mouthwash 0.2%.....	2.57	200 ml OP	✓	healthE
CHOLINE SALICYLATE WITH CETALKONIUM CHLORIDE				
* Adhesive gel 8.7% with cetalkonium chloride 0.01%	2.06 (6.00)	15 g OP		Bonjela
TRIAMCINOLONE ACETONIDE				
Paste 0.1%	5.33	5 g OP	✓	Kenalog in Orabase

Oropharyngeal Anti-infectives

AMPHOTERICIN B				
Lozenges 10 mg.....	5.86	20	✓	Fungilin
MICONAZOLE				
Oral gel 20 mg per g.....	4.74	40 g OP	✓	Decozol
NYSTATIN				
Oral liq 100,000 u per ml	1.95	24 ml OP	✓	Nilstat

Other Oral Agents

For folinic mouthwash, pilocarpine oral liquid or saliva substitute formula refer Standard Formulae, [page 215](#)

HYDROGEN PEROXIDE				
* Soln 3% (10 vol) – Maximum of 200 ml per prescription.....	1.40	100 ml	✓	Pharmacy Health
THYMOL GLYCERIN				
* Compound, BPC.....	9.15	500 ml	✓	PSM

Vitamins

Vitamin A

VITAMIN A WITH VITAMINS D AND C				
* Soln 1000 u with Vitamin D 400 u and ascorbic acid 30 mg per 10 drops.....	4.50	10 ml OP	✓	Vitadol C
<i>(Vitadol C Soln 1000 u with Vitamin D 400 u and ascorbic acid 30 mg per 10 drops to be delisted 1 August 2019)</i>				

Vitamin B

HYDROXOCOBALAMIN				
* Inj 1 mg per ml, 1 ml ampoule – Up to 6 inj available on a PSO	1.89	3	✓	Neo-B12
PYRIDOXINE HYDROCHLORIDE				
a) No more than 100 mg per dose				
b) Only on a prescription				
* Tab 25 mg – No patient co-payment payable.....	2.70	90	✓	Vitamin B6 25
* Tab 50 mg	13.63	500	✓	Apo-Pyridoxine
THIAMINE HYDROCHLORIDE – Only on a prescription				
* Tab 50 mg	4.89 (5.62)	100	✓	Max Health Apo-Thiamine
Max Health to be Sole Supply on 1 February 2019 (Apo-Thiamine Tab 50 mg to be delisted 1 February 2019)				
VITAMIN B COMPLEX				
* Tab, strong, BPC.....	7.15	500	✓	Bplex

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

Vitamin C

ASCORBIC ACID

- a) No more than 100 mg per dose
- b) Only on a prescription

* Tab 100 mg 8.10 500 ✓ **Cvite**

Vitamin D

ALFACALCIDOL

* Cap 0.25 mcg 26.32 100 ✓ **One-Alpha**
 * Cap 1 mcg 87.98 100 ✓ **One-Alpha**
 * Oral drops 2 mcg per ml 60.68 20 ml OP ✓ **One-Alpha**

CALCITRIOL

* Cap 0.25 mcg 9.95 100 ✓ **Calcitriol-AFT**
 * Cap 0.5 mcg 18.39 100 ✓ **Calcitriol-AFT**

COLECALCIFEROL

* Cap 1.25 mg (50,000 iu) – Maximum of 12 cap per prescription 2.50 12 ✓ **Vit.D3**

Multivitamin Preparations

MULTIVITAMIN RENAL – Special Authority see [SA1546 below](#) – Retail pharmacy

* Cap 6.49 30 ✓ **Clinicians Renal Vit**

► [SA1546](#) Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Either:

- 1 The patient has chronic kidney disease and is receiving either peritoneal dialysis or haemodialysis; or
- 2 The patient has chronic kidney disease grade 5, defined as patient with an estimated glomerular filtration rate of < 15 ml/min/1.73 m² body surface area (BSA).

MULTIVITAMINS – Special Authority see [SA1036 below](#) – Retail pharmacy

* Powder 72.00 200 g OP ✓ **Paediatric Seravit**

► [SA1036](#) Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid without further renewal unless notified where the patient has inborn errors of metabolism.

Renewal from any relevant practitioner. Approvals valid without further renewal unless notified where patient has had a previous approval for multivitamins.

VITAMINS

* Tab (BPC cap strength) 10.50 1,000 ✓ **Mvite**
 * Cap (fat soluble vitamins A, D, E, K) – Special Authority see
[SA1720 below](#) – Retail pharmacy 23.40 60 ✓ **Vitabdeck**

► [SA1720](#) Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Any of the following:

- 1 Patient has cystic fibrosis with pancreatic insufficiency; or
- 2 Patient is an infant or child with liver disease or short gut syndrome; or
- 3 Patient has severe malabsorption syndrome.

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
Minerals				
Calcium				
CALCIUM CARBONATE				
* Tab eff 1.75 g (1 g elemental)	2.07	10	✓	Calsource
* Tab 1.25 g (500 mg elemental)	7.52	250	✓	Arrow-Calcium
CALCIUM GLUCONATE				
* Inj 10%, 10 ml ampoule	34.24	10	✓	Hospira
Fluoride				
SODIUM FLUORIDE				
* Tab 1.1 mg (0.5 mg elemental)	5.75	100	✓	PSM
Iodine				
POTASSIUM IODATE				
* Tab 253 mcg (150 mcg elemental iodine)	4.69	90	✓	NeuroTabs
Iron				
FERRIC CARBOXYMALTOSE – Special Authority see SA1675 below – Retail pharmacy				
Inj 50 mg per ml, 10 ml	150.00	1	✓	Ferinject
➔SA1675 Special Authority for Subsidy				
Initial application — (serum ferritin less than or equal to 20 mcg/L) from any medical practitioner. Approvals valid for 3 months for applications meeting the following criteria:				
Both:				
1 Patient has been diagnosed with iron-deficiency anaemia with a serum ferritin level of less than or equal to 20 mcg/L; and				
2 Any of the following:				
2.1 Patient has been compliant with oral iron treatment and treatment has proven ineffective; or				
2.2 Treatment with oral iron has resulted in dose-limiting intolerance; or				
2.3 Rapid correction of anaemia is required.				
Renewal — (serum ferritin less than or equal to 20 mcg/L) from any medical practitioner. Approvals valid for 3 months for applications meeting the following criteria:				
Both:				
1 Patient continues to have iron-deficiency anaemia with a serum ferritin level of less than or equal to 20 mcg/L; and				
2 A re-trial with oral iron is clinically inappropriate.				
Initial application — (iron deficiency anaemia) only from an internal medicine physician, obstetrician, gynaecologist, anaesthetist or medical practitioner on the recommendation of a internal medicine physician, obstetrician, gynaecologist or anaesthetist. Approvals valid for 3 months for applications meeting the following criteria:				
Both:				
1 Patient has been diagnosed with iron-deficiency anaemia; and				
2 Any of the following:				
2.1 Patient has been compliant with oral iron treatment and treatment has proven ineffective; or				
2.2 Treatment with oral iron has resulted in dose-limiting intolerance; or				
2.3 Patient has symptomatic heart failure, chronic kidney disease stage 3 or more or active inflammatory bowel disease and a trial of oral iron is unlikely to be effective; or				

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

2.4 Rapid correction of anaemia is required.

Renewal — (iron deficiency anaemia) only from an internal medicine physician, obstetrician, gynaecologist, anaesthetist or medical practitioner on the recommendation of a internal medicine physician, obstetrician, gynaecologist or anaesthetist.

Approvals valid for 3 months for applications meeting the following criteria:

Both:

- 1 Patient continues to have iron-deficiency anaemia; and
- 2 A re-trial with oral iron is clinically inappropriate.

FERROUS FUMARATE

* Tab 200 mg (65 mg elemental)3.09 100 ✓ **Ferro-tab**
Ferro-tab to be Sole Supply on 1 February 2019

FERROUS FUMARATE WITH FOLIC ACID

* Tab 310 mg (100 mg elemental) with folic acid 350 mcg4.68 60 ✓ **Ferro-F-Tabs**

FERROUS SULPHATE

Tab long-acting 325 mg (105 mg elemental)2.06 30 ✓ **Ferrograd**
* Oral liq 30 mg (6 mg elemental) per 1 ml10.80 500 ml ✓ **Ferodan**

IRON POLYMALTOSE

* Inj 50 mg per ml, 2 ml ampoule15.22 5 ✓ **Ferrum H**
(*Ferrum H Inj 50 mg per ml, 2 ml ampoule to be delisted 1 April 2019*)

Magnesium

For magnesium hydroxide mixture refer Standard Formulae, [page 215](#)

MAGNESIUM SULPHATE

* Inj 2 mmol per ml, 5 ml ampoule10.21 10 ✓ **DBL**

Zinc

ZINC SULPHATE

* Cap 137.4 mg (50 mg elemental)11.00 100 ✓ **Zincaps**

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

Antianaemics

Hypoplastic and Haemolytic

►SA1469 Special Authority for Subsidy

Initial application — (chronic renal failure) from any specialist. Approvals valid for 2 years for applications meeting the following criteria:

All of the following:

- 1 Patient in chronic renal failure; and
- 2 Haemoglobin is less than or equal to 100g/L; and
- 3 Any of the following:
 - 3.1 Both:
 - 3.1.1 Patient does not have diabetes mellitus; and
 - 3.1.2 Glomerular filtration rate is less than or equal to 30ml/min; or
 - 3.2 Both:
 - 3.2.1 Patient has diabetes mellitus; and
 - 3.2.2 Glomerular filtration rate is less than or equal to 45ml/min; or
 - 3.3 Patient is on haemodialysis or peritoneal dialysis.

Note: Erythropoietin alfa is indicated in the treatment of anaemia associated with chronic renal failure (CRF) where no cause for anaemia other than CRF is detected and there is adequate monitoring of iron stores and iron replacement therapy.

Initial application — (myelodysplasia) from any specialist. Approvals valid for 2 months for applications meeting the following criteria:

All of the following:

- 1 Patient has a confirmed diagnosis of myelodysplasia (MDS)*; and
- 2 Has had symptomatic anaemia with haemoglobin < 100g/L and is red cell transfusion-dependent; and
- 3 Patient has very low, low or intermediate risk MDS based on the WHO classification based prognostic scoring system for myelodysplastic syndrome (WPSS); and
- 4 Other causes of anaemia such as B12 and folate deficiency have been excluded; and
- 5 Patient has a serum erythropoietin level of < 500 IU/L; and
- 6 The minimum necessary dose of erythropoietin would be used and will not exceed 80,000 iu per week.

Note: Indication marked with * is an unapproved indication

Renewal — (chronic renal failure) from any specialist. Approvals valid for 2 years where the treatment remains appropriate and the patient is benefiting from treatment.

Note: Erythropoietin alfa is indicated in the treatment of anaemia associated with chronic renal failure (CRF) where no cause for anaemia other than CRF is detected and there is adequate monitoring of iron stores and iron replacement therapy.

Renewal — (myelodysplasia) from any specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient's transfusion requirement continues to be reduced with erythropoietin treatment; and
- 2 Transformation to acute myeloid leukaemia has not occurred; and
- 3 The minimum necessary dose of erythropoietin would be used and will not exceed 80,000 iu per week.

Note: Indication marked with * is an unapproved indication

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
EPOETIN ALFA [ERYTHROPOIETIN ALFA] – Special Authority see SA1469 on the previous page – Retail pharmacy				
Wastage claimable				
Inj 1,000 iu in 0.5 ml, syringe.....	48.68	6	✓	Eprex
Inj 2,000 iu in 0.5 ml, syringe.....	120.18	6	✓	Eprex
Inj 3,000 iu in 0.3 ml, syringe.....	166.87	6	✓	Eprex
Inj 4,000 iu in 0.4 ml, syringe.....	193.13	6	✓	Eprex
Inj 5,000 iu in 0.5 ml, syringe.....	243.26	6	✓	Eprex
Inj 6,000 iu in 0.6 ml, syringe.....	291.92	6	✓	Eprex
Inj 8,000 iu in 0.8 ml, syringe.....	352.69	6	✓	Eprex
Inj 10,000 iu in 1 ml, syringe.....	395.18	6	✓	Eprex
Inj 40,000 iu in 1 ml, syringe.....	263.45	1	✓	Eprex

Megaloblastic

FOLIC ACID

* Tab 0.8 mg	21.84	1,000	✓	Apo-Folic Acid
* Tab 5 mg	12.12	500	✓	Apo-Folic Acid
Oral liq 50 mcg per ml	24.00	25 ml OP	✓	Biomed

Antifibrinolytics, Haemostatics and Local Sclerosants

ELTROMBOPAG – Special Authority see [SA1743 below](#) – Retail pharmacy

Wastage claimable				
Tab 25 mg	1,550.00	28	✓	Revolade
Tab 50 mg	3,100.00	28	✓	Revolade

► [SA1743](#) Special Authority for Subsidy

Initial application — (idiopathic thrombocytopenic purpura - post-splenectomy) only from a haematologist. Approvals valid for 6 weeks for applications meeting the following criteria:

All of the following:

- 1 Patient has had a splenectomy; and
- 2 Two immunosuppressive therapies have been trialled and failed after therapy of 3 months each (or 1 month for rituximab); and
- 3 Any of the following:
 - 3.1 Patient has a platelet count of 20,000 to 30,000 platelets per microlitre and has evidence of significant mucocutaneous bleeding; or
 - 3.2 Patient has a platelet count of less than or equal to 20,000 platelets per microlitre and has evidence of active bleeding; or
 - 3.3 Patient has a platelet count of less than or equal to 10,000 platelets per microlitre.

Initial application — (idiopathic thrombocytopenic purpura - preparation for splenectomy) only from a haematologist.

Approvals valid for 6 weeks where the patient requires eltrombopag treatment as preparation for splenectomy.

Initial application — (idiopathic thrombocytopenic purpura contraindicated to splenectomy) only from a haematologist.

Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 Patient has a significant and well-documented contraindication to splenectomy for clinical reasons; and
- 2 Two immunosuppressive therapies have been trialled and failed after therapy of 3 months each (or 1 month for rituximab); and
- 3 Either:
 - 3.1 Patient has immune thrombocytopenic purpura* with a platelet count of less than or equal to 20,000 platelets per microliter; or

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

- 3.2 Patient has immune thrombocytopenic purpura* with a platelet count of 20,000 to 30,000 platelets per microlitre and significant mucocutaneous bleeding.

Initial application — (severe aplastic anaemia) only from a haematologist. Approvals valid for 3 months for applications meeting the following criteria:

Both:

- 1 Two immunosuppressive therapies have been trialled and failed after therapy of at least 3 months duration; and
- 2 Either:
 - 2.1 Patient has severe aplastic anaemia with a platelet count of less than or equal to 20,000 platelets per microlitre; or
 - 2.2 Patient has severe aplastic anaemia with a platelet count of 20,000 to 30,000 platelets per microlitre and significant mucocutaneous bleeding.

Renewal — (idiopathic thrombocytopenic purpura - post-splenectomy) only from a haematologist. Approvals valid for 12 months where the patient has obtained a response (see Note) from treatment during the initial approval or subsequent renewal periods and further treatment is required.

Note: Response to treatment is defined as a platelet count of > 30,000 platelets per microlitre.

Renewal — (idiopathic thrombocytopenic purpura contraindicated to splenectomy) only from a haematologist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient's significant contraindication to splenectomy remains; and
- 2 The patient has obtained a response from treatment during the initial approval period; and
- 3 Patient has maintained a platelet count of at least 50,000 platelets per microlitre on treatment; and
- 4 Further treatment with eltrombopag is required to maintain response.

Renewal — (severe aplastic anaemia) only from a haematologist. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 The patient has obtained a response from treatment of at least 20,000 platelets per microlitre above baseline during the initial approval period; and
- 2 Platelet transfusion independence for a minimum of 8 weeks during the initial approval period.

EPTACOG ALFA [RECOMBINANT FACTOR VIIA] – [Xpharm]

For patients with haemophilia, whose funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group.

Inj 1 mg syringe	1,178.30	1	✓ NovoSeven RT
Inj 2 mg syringe	2,356.60	1	✓ NovoSeven RT
Inj 5 mg syringe	5,891.50	1	✓ NovoSeven RT
Inj 8 mg syringe	9,426.40	1	✓ NovoSeven RT

FACTOR EIGHT INHIBITOR BYPASSING FRACTION – [Xpharm]

For patients with haemophilia, whose funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group.

Inj 500 U	1,450.00	1	✓ FEIBA NF
Inj 1,000 U	2,900.00	1	✓ FEIBA NF
Inj 2,500 U	7,250.00	1	✓ FEIBA NF

MOROCTOCOG ALFA [RECOMBINANT FACTOR VIII] – [Xpharm]

Preferred Brand of recombinant factor VIII for patients with haemophilia from 1 March 2016 until 28 February 2019. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group.

Inj 250 iu prefilled syringe	210.00	1	✓ Xyntha
Inj 500 iu prefilled syringe	420.00	1	✓ Xyntha
Inj 1,000 iu prefilled syringe	840.00	1	✓ Xyntha
Inj 2,000 iu prefilled syringe	1,680.00	1	✓ Xyntha
Inj 3,000 iu prefilled syringe	2,520.00	1	✓ Xyntha

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

* Three months or six months, as applicable, dispensed all-at-once

BLOOD AND BLOOD FORMING ORGANS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
NONACOG ALFA [RECOMBINANT FACTOR IX] – [Xpharm]				
For patients with haemophilia, whose funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group.				
Inj 250 iu vial.....	310.00	1	✓	BeneFIX
Inj 500 iu vial.....	620.00	1	✓	BeneFIX
Inj 1,000 iu vial.....	1,240.00	1	✓	BeneFIX
Inj 2,000 iu vial.....	2,480.00	1	✓	BeneFIX
Inj 3,000 iu vial.....	3,720.00	1	✓	BeneFIX
NONACOG GAMMA, [RECOMBINANT FACTOR IX] – [Xpharm]				
For patients with haemophilia, whose funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group.				
Inj 250 iu vial.....	287.50	1	✓	RIXUBIS
Inj 500 iu vial.....	575.00	1	✓	RIXUBIS
Inj 1,000 iu vial.....	1,150.00	1	✓	RIXUBIS
Inj 2,000 iu vial.....	2,300.00	1	✓	RIXUBIS
Inj 3,000 iu vial.....	3,450.00	1	✓	RIXUBIS
OCTOCOG ALFA [RECOMBINANT FACTOR VIII] (ADVATE) – [Xpharm]				
Rare Clinical Circumstances Brand of recombinant factor VIII for patients with haemophilia from 1 March 2016 until 28 February 2019. Access to funded treatment by application to the Haemophilia Treatments Panel. Application details may be obtained from PHARMAC's website http://www.pharmac.govt.nz or:				
The Co-ordinator, Haemophilia Treatments Panel	Phone: 0800 023 588 Option 2			
PHARMAC PO Box 10 254	Facsimile: (04) 974 4881			
Wellington	Email: haemophilia@pharmac.govt.nz			
Inj 250 iu vial.....	287.50	1	✓	Advate
Inj 500 iu vial.....	575.00	1	✓	Advate
Inj 1,000 iu vial.....	1,150.00	1	✓	Advate
Inj 1,500 iu vial.....	1,725.00	1	✓	Advate
Inj 2,000 iu vial.....	2,300.00	1	✓	Advate
Inj 3,000 iu vial.....	3,450.00	1	✓	Advate
OCTOCOG ALFA [RECOMBINANT FACTOR VIII] (KOGENATE FS) – [Xpharm]				
Second Brand of recombinant factor VIII for patients with haemophilia from 1 March 2016 until 28 February 2019. Access to funded treatment by application to the Haemophilia Treatments Panel. Application details may be obtained from PHARMAC's website http://www.pharmac.govt.nz or:				
The Co-ordinator, Haemophilia Treatments Panel	Phone: 0800 023 588 Option 2			
PHARMAC PO Box 10 254	Facsimile: (04) 974 4881			
Wellington	Email: haemophilia@pharmac.govt.nz			
Inj 250 iu vial.....	237.50	1	✓	Kogenate FS
Inj 500 iu vial.....	475.00	1	✓	Kogenate FS
Inj 1,000 iu vial.....	950.00	1	✓	Kogenate FS
Inj 2,000 iu vial.....	1,900.00	1	✓	Kogenate FS
Inj 3,000 iu vial.....	2,850.00	1	✓	Kogenate FS
SODIUM TETRADECYL SULPHATE				
* Inj 3% 2 ml.....	28.50 (73.00)	5		Fibro-vein
TRANEXAMIC ACID				
Tab 500 mg	20.67	100	✓	Cyklokapron

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
Vitamin K				
PHYTOMENADIONE				
Inj 2 mg per 0.2 ml – Up to 5 inj available on a PSO.....	8.00	5	✓	Konakion MM
Inj 10 mg per ml, 1 ml – Up to 5 inj available on a PSO.....	9.21	5	✓	Konakion MM

Antithrombotic Agents

Antiplatelet Agents

ASPIRIN				
* Tab 100 mg	12.50	990	✓	Ethics Aspirin EC
CLOPIDOGREL				
* Tab 75 mg	5.44	84	✓	Arrow - Clopid
DIPYRIDAMOLE				
* Tab long-acting 150 mg.....	11.52	60	✓	Pytazen SR
PRASUGREL – Special Authority see SA1201 below – Retail pharmacy				
Tab 5 mg	108.00	28	✓	Effient
Tab 10 mg	120.00	28	✓	Effient

►SA1201 Special Authority for Subsidy

Initial application — (coronary angioplasty and bare metal stent) from any relevant practitioner. Approvals valid for 6 months where the patient has undergone coronary angioplasty in the previous 4 weeks and is clopidogrel-allergic*.

Initial application — (drug eluting stent) from any relevant practitioner. Approvals valid for 12 months where the patient has had a drug-eluting cardiac stent inserted in the previous 4 weeks and is clopidogrel-allergic*.

Initial application — (stent thrombosis) from any relevant practitioner. Approvals valid without further renewal unless notified where patient has experienced cardiac stent thrombosis whilst on clopidogrel.

Renewal — (coronary angioplasty and bare metal stent) from any relevant practitioner. Approvals valid for 6 months where the patient has undergone coronary angioplasty or had a bare metal cardiac stent inserted in the previous 4 weeks and is clopidogrel-allergic*.

Renewal — (drug eluting stent) from any relevant practitioner. Approvals valid for 12 months where had a drug-eluting cardiac stent inserted in the previous 4 weeks and is clopidogrel-allergic*.

Note: * Clopidogrel allergy is defined as a history of anaphylaxis, urticaria, generalised rash or asthma (in non-asthmatic patients) developing soon after clopidogrel is started and is considered unlikely to be caused by any other treatment.

TICAGRELOR – Special Authority see SA1382 below – Retail pharmacy

* Tab 90 mg	90.00	56	✓	Brilinta
-------------------	-------	----	---	----------

►SA1382 Special Authority for Subsidy

Initial application — (acute coronary syndrome) from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 Patient has recently (within the last 60 days) been diagnosed with an ST-elevation or a non-ST-elevation acute coronary syndrome; and
- 2 Fibrinolytic therapy has not been given in the last 24 hours and is not planned.

Renewal — (subsequent acute coronary syndrome) from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 Patient has recently (within the last 60 days) been diagnosed with an ST-elevation or a non-ST-elevation acute coronary syndrome; and
- 2 Fibrinolytic therapy has not been given in the last 24 hours and is not planned.

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

Heparin and Antagonist Preparations

DALTEPARIN SODIUM – Special Authority see [SA1270 below](#) – Retail pharmacy

Inj 2,500 iu per 0.2 ml prefilled syringe.....	19.97	10	✓	Fragmin
Inj 5,000 iu per 0.2 ml prefilled syringe.....	39.94	10	✓	Fragmin
Inj 7,500 iu per 0.75 ml graduated syringe.....	60.03	10	✓	Fragmin
Inj 10,000 iu per 1 ml graduated syringe.....	77.55	10	✓	Fragmin
Inj 12,500 iu per 0.5 ml prefilled syringe.....	99.96	10	✓	Fragmin
Inj 15,000 iu per 0.6 ml prefilled syringe.....	120.05	10	✓	Fragmin
Inj 18,000 iu per 0.72 ml prefilled syringe.....	158.47	10	✓	Fragmin

➤SA1270 Special Authority for Subsidy

Initial application — (Pregnancy or Malignancy) from any relevant practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Either:

- 1 Low molecular weight heparin treatment is required during a patient's pregnancy; or
- 2 For the treatment of venous thromboembolism where the patient has a malignancy.

Initial application — (Venous thromboembolism other than in pregnancy or malignancy) from any relevant practitioner.

Approvals valid for 1 month for applications meeting the following criteria:

Any of the following:

- 1 For the short-term treatment of venous thromboembolism prior to establishing a therapeutic level of oral anti-coagulant treatment; or
- 2 For the prophylaxis and treatment of venous thromboembolism in high risk surgery; or
- 2 To enable cessation/re-establishment of existing oral anticoagulant treatment pre/post surgery; or
- 4 For the prophylaxis and treatment of venous thromboembolism in Acute Coronary Syndrome surgical intervention; or
- 5 To be used in association with cardioversion of atrial fibrillation.

Renewal — (Pregnancy or Malignancy) from any relevant practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Either:

- 1 Low molecular weight heparin treatment is required during a patient's pregnancy; or
- 2 For the treatment of venous thromboembolism where the patient has a malignancy.

Renewal — (Venous thromboembolism other than in pregnancy or malignancy) from any relevant practitioner. Approvals valid for 1 month where low molecular weight heparin treatment or prophylaxis is required for a second or subsequent event (surgery, Acute Coronary Syndrome, cardioversion, or prior to oral anti-coagulation).

ENOXAPARIN SODIUM – Special Authority see [SA1646 below](#) – Retail pharmacy

Inj 20 mg in 0.2 ml syringe.....	27.93	10	✓	Clexane
Inj 40 mg in 0.4 ml syringe.....	37.27	10	✓	Clexane
Inj 60 mg in 0.6 ml syringe.....	56.18	10	✓	Clexane
Inj 80 mg in 0.8 ml syringe.....	74.90	10	✓	Clexane
Inj 100 mg in 1 ml syringe.....	93.80	10	✓	Clexane
Inj 120 mg in 0.8 ml syringe.....	116.55	10	✓	Clexane
Inj 150 mg in 1 ml syringe.....	133.20	10	✓	Clexane

➤SA1646 Special Authority for Subsidy

Initial application — (Pregnancy, Malignancy or Haemodialysis) from any relevant practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Any of the following:

- 1 Low molecular weight heparin treatment is required during a patients pregnancy; or
- 2 For the treatment of venous thromboembolism where the patient has a malignancy; or

continued...

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
--	---	------------------------------	-------------------------------------

continued...

3 For the prevention of thrombus formation in the extra-corporeal circulation during haemodialysis.

Initial application — (Venous thromboembolism other than in pregnancy or malignancy) from any relevant practitioner.

Approvals valid for 1 month for applications meeting the following criteria:

Any of the following:

- 1 For the short-term treatment of venous thromboembolism prior to establishing a therapeutic level of oral anti-coagulant treatment; or
- 2 For the prophylaxis and treatment of venous thromboembolism in high risk surgery; or
- 3 To enable cessation/re-establishment of existing oral anticoagulant treatment pre/post surgery; or
- 4 For the prophylaxis and treatment of venous thromboembolism in Acute Coronary Syndrome surgical intervention; or
- 5 To be used in association with cardioversion of atrial fibrillation.

Renewal — (Pregnancy, Malignancy or Haemodialysis) from any relevant practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Any of the following:

- 1 Low molecular weight heparin treatment is required during a patient's pregnancy; or
- 2 For the treatment of venous thromboembolism where the patient has a malignancy; or
- 3 For the prevention of thrombus formation in the extra-corporeal circulation during haemodialysis.

Renewal — (Venous thromboembolism other than in pregnancy or malignancy) from any relevant practitioner. Approvals valid for 1 month where low molecular weight heparin treatment or prophylaxis is required for a second or subsequent event (surgery, ACS, cardioversion, or prior to oral anti-coagulation).

HEPARIN SODIUM

Inj 1,000 iu per ml, 35 ml vial.....	14.53	1	✓ Hospira
Inj 1,000 iu per ml, 5 ml ampoule	58.57	50	✓ Pfizer
	(66.80)		Hospira

Pfizer to be Sole Supply on 1 February 2019

Inj 5,000 iu per ml, 1 ml	28.40	5	✓ Hospira
Inj 5,000 iu per ml, 5 ml ampoule	203.68	50	✓ Pfizer

Pfizer to be Sole Supply on 1 December 2018

Inj 25,000 iu per ml, 0.2 ml	19.00	5	✓ Hospira
------------------------------------	-------	---	-----------

(Hospira Inj 1,000 iu per ml, 35 ml vial to be delisted 1 February 2019)

(Hospira Inj 1,000 iu per ml, 5 ml ampoule to be delisted 1 February 2019)

HEPARINISED SALINE

Inj 10 iu per ml, 5 ml	53.40	30	✓ BD PosiFlush ^{\$29}
	56.94	50	✓ Pfizer

(BD PosiFlush ^{\$29} Inj 10 iu per ml, 5 ml to be delisted 1 March 2019)

Oral Anticoagulants

DABIGATRAN

Cap 75 mg – No more than 2 cap per day	76.36	60	✓ Pradaxa
Cap 110 mg	76.36	60	✓ Pradaxa
Cap 150 mg	76.36	60	✓ Pradaxa

RIVAROXABAN

Tab 10 mg – No more than 1 tab per day	83.10	30	✓ Xarelto
Tab 15 mg	77.56	28	✓ Xarelto
Tab 20 mg	77.56	28	✓ Xarelto

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

BLOOD AND BLOOD FORMING ORGANS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
WARFARIN SODIUM				
Note: Marevan and Coumadin are not interchangeable.				
* Tab 1 mg	3.46	50	✓	Coumadin
	6.86	100	✓	Marevan
* Tab 2 mg	4.31	50	✓	Coumadin
* Tab 3 mg	9.70	100	✓	Marevan
* Tab 5 mg	5.93	50	✓	Coumadin
	11.75	100	✓	Marevan

Blood Colony-stimulating Factors

FILGRASTIM – Special Authority see [SA1259 below](#) – Retail pharmacy

Inj 300 mcg per 0.5 ml prefilled syringe.....	270.00	5	✓	Zarzio
Inj 480 mcg per 0.5 ml prefilled syringe.....	432.00	5	✓	Zarzio

► [SA1259](#) Special Authority for Subsidy

Initial application only from a relevant specialist, vocationally registered general practitioner or medical practitioner on the recommendation of a relevant specialist. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Any of the following:

- 1 Prevention of neutropenia in patients undergoing high risk chemotherapy for cancer (febrile neutropenia risk greater than or equal to 20%*); or
- 2 Peripheral blood stem cell mobilisation in patients undergoing haematological transplantation; or
- 3 Peripheral blood stem cell mobilisation or bone marrow donation from healthy donors for transplantation; or
- 4 Treatment of severe chronic neutropenia ($ANC < 0.5 \times 10^9/L$); or
- 5 Treatment of drug-induced prolonged neutropenia ($ANC < 0.5 \times 10^9/L$).

Note: *Febrile neutropenia risk greater than or equal to 20% after taking into account other risk factors as defined by the European Organisation for Research and Treatment of Cancer (EORTC) guidelines.

PEGFILGRASTIM – Special Authority see [SA1384 below](#) – Retail pharmacy

Inj 6 mg per 0.6 ml syringe	1,080.00	1	✓	Neulastim
-----------------------------------	----------	---	---	-----------

► [SA1384](#) Special Authority for Subsidy

Initial application only from a relevant specialist, vocationally registered general practitioner or medical practitioner on the recommendation of a relevant specialist. Approvals valid without further renewal unless notified where used for prevention of neutropenia in patients undergoing high risk chemotherapy for cancer (febrile neutropenia risk greater than or equal to 20%*).

Note: *Febrile neutropenia risk greater than or equal to 20% after taking into account other risk factors as defined by the European Organisation for Research and Treatment of Cancer (EORTC) guidelines.

Fluids and Electrolytes

Intravenous Administration

GLUCOSE [DEXTROSE]

* Inj 50%, 10 ml ampoule – Up to 5 inj available on a PSO	29.50	5	✓	Biomed
* Inj 50%, 90 ml bottle – Up to 5 inj available on a PSO	14.50	1	✓	Biomed

POTASSIUM CHLORIDE

* Inj 75 mg per ml, 10 ml	55.00	50	✓	AstraZeneca
---------------------------------	-------	----	---	-------------

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
SODIUM BICARBONATE				
Inj 8.4%, 50 ml.....	19.95	1	✓	Biomed
a) Up to 5 inj available on a PSO				
b) Not in combination				
Inj 8.4%, 100 ml.....	20.50	1	✓	Biomed
a) Up to 5 inj available on a PSO				
b) Not in combination				
SODIUM CHLORIDE				
Not funded for use as a nasal drop. Only funded for nebuliser use when in conjunction with an antibiotic intended for nebuliser use.				
Inj 0.9%, bag – Up to 2000 ml available on a PSO	1.23	500 ml	✓	Baxter
	1.26	1,000 ml	✓	Baxter
Only if prescribed on a prescription for renal dialysis, maternity or post-natal care in the home of the patient, or on a PSO for emergency use. (500 ml and 1,000 ml packs)				
Inj 23.4% (4 mmol/ml), 20 ml ampoule.....	33.00	5	✓	Biomed
For Sodium chloride oral liquid formulation refer Standard Formulae, page 215				
Inj 0.9%, 5 ml ampoule – Up to 5 inj available on a PSO	7.00	50	✓	InterPharma
			✓	Multichem
Inj 0.9%, 10 ml ampoule – Up to 5 inj available on a PSO	6.63	50	✓	Pfizer
Inj 0.9%, 20 ml ampoule.....	5.00	20	✓	Multichem
	7.50	30	✓	InterPharma
TOTAL PARENTERAL NUTRITION (TPN) – Retail pharmacy-Specialist				
Infusion.....	CBS	1 OP	✓	TPN
WATER				
1) On a prescription or Practitioner's Supply Order only when on the same form as an injection listed in the Pharmaceutical Schedule requiring a solvent or diluent; or				
2) On a bulk supply order; or				
3) When used in the extemporaneous compounding of eye drops; or				
4) When used for the dilution of sodium chloride soln 7% for cystic fibrosis patients only.				
Inj 5 ml ampoule – Up to 5 inj available on a PSO	7.00	50	✓	InterPharma
Inj 10 ml ampoule – Up to 5 inj available on a PSO	6.63	50	✓	Pfizer
Inj 20 ml ampoule – Up to 5 inj available on a PSO	5.00	20	✓	Multichem
	7.50	30	✓	InterPharma
Oral Administration				
CALCIUM POLYSTYRENE SULPHONATE				
Powder	169.85	300 g OP	✓	Calcium Resonium
COMPOUND ELECTROLYTES				
Powder for oral soln – Up to 10 sach available on a PSO.....	2.30	10	✓	Enerlyte
COMPOUND ELECTROLYTES WITH GLUCOSE [DEXTROSE]				
Soln with electrolytes (2 x 500 ml)	6.55	1,000 ml OP	✓	Pedialyte - Bubblégum
Pedialyte - Bubblégum to be Sole Supply on 1 December 2018				
PHOSPHORUS				
Tab eff 500 mg (16 mmol)	82.50	100	✓	Phosphate-Sandoz

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

BLOOD AND BLOOD FORMING ORGANS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
POTASSIUM CHLORIDE				
* Tab eff 548 mg (14 m eq) with chloride 285 mg (8 m eq).....	5.26 (11.85)	60		Chlorvescent
* Tab long-acting 600 mg (8 mmol).....	8.90	200	✓	<u>Span-K</u>
SODIUM BICARBONATE				
Cap 840 mg.....	8.52	100	✓	Sodibic
			✓	Sodibic
SODIUM POLYSTYRENE SULPHONATE				
Powder	84.65	454 g OP	✓	<u>Resonium-A</u>

Subsidy (Manufacturer's Price)	Fully Subsidised	Brand or Generic Manufacturer
\$	Per	✓

Alpha-Adrenoceptor Blockers

Alpha Adrenoceptor Blockers

DOXAZOSIN

* Tab 2 mg	6.75	500	✓ <u>Apo-Doxazosin</u>
* Tab 4 mg	9.09	500	✓ <u>Apo-Doxazosin</u>

PHENOXYBENZAMINE HYDROCHLORIDE

* Cap 10 mg	65.00	30	✓ <u>BNM</u> ^{\$29}
	216.67	100	✓ <u>Dibenzylamine</u> ^{\$29}

PRAZOSIN

* Tab 1 mg	5.53	100	✓ <u>Apo-Prazosin</u>
* Tab 2 mg	7.00	100	✓ <u>Apo-Prazosin</u>
* Tab 5 mg	11.70	100	✓ <u>Apo-Prazosin</u>

TERAZOSIN

* Tab 1 mg	0.59	28	✓ <u>Actavis</u>
* Tab 2 mg	7.50	500	✓ <u>Apo-Terazosin</u>
* Tab 5 mg	10.90	500	✓ <u>Apo-Terazosin</u>

Agents Affecting the Renin-Angiotensin System

ACE Inhibitors

CAPTOPRIL

* Oral liq 5 mg per ml	94.99	95 ml OP	✓ <u>Capoten</u>
Oral liquid restricted to children under 12 years of age.			

CILAZAPRIL

* Tab 0.5 mg	2.00	90	✓ <u>Zapril</u>
* Tab 2.5 mg	7.20	200	✓ <u>Apo-Cilazapril</u>
* Tab 5 mg	12.00	200	✓ <u>Apo-Cilazapril</u>

ENALAPRIL MALEATE

* Tab 5 mg	0.96	100	✓ <u>Ethics Enalapril</u>
* Tab 10 mg	1.24	100	✓ <u>Ethics Enalapril</u>
* Tab 20 mg	1.78	100	✓ <u>Ethics Enalapril</u>

LISINOPRIL

* Tab 5 mg	2.07	90	✓ <u>Ethics Lisinopril</u>
Ethics Lisinopril to be Sole Supply on 1 January 2019			
* Tab 10 mg	2.36	90	✓ <u>Ethics Lisinopril</u>
Ethics Lisinopril to be Sole Supply on 1 January 2019			
* Tab 20 mg	3.17	90	✓ <u>Ethics Lisinopril</u>
Ethics Lisinopril to be Sole Supply on 1 January 2019			

PERINDOPRIL

* Tab 2 mg	3.75	30	✓ <u>Apo-Perindopril</u>
* Tab 4 mg	4.80	30	✓ <u>Apo-Perindopril</u>

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
QUINAPRIL				
* Tab 5 mg	6.01	90	✓	Arrow-Quinapril 5
Arrow-Quinapril 5 to be Sole Supply on 1 December 2018				
* Tab 10 mg	3.16	90	✓	Arrow-Quinapril 10
Arrow-Quinapril 10 to be Sole Supply on 1 December 2018				
* Tab 20 mg	4.89	90	✓	Arrow-Quinapril 20
Arrow-Quinapril 20 to be Sole Supply on 1 December 2018				

ACE Inhibitors with Diuretics

CILAZAPRIL WITH HYDROCHLOROTHIAZIDE				
* Tab 5 mg with hydrochlorothiazide 12.5 mg.....	10.18	100	✓	Apo-Cilazapril/ Hydrochlorothiazide
QUINAPRIL WITH HYDROCHLOROTHIAZIDE				
* Tab 10 mg with hydrochlorothiazide 12.5 mg.....	3.83	30	✓	Accuretic 10
Accuretic 10 to be Sole Supply on 1 January 2019				
* Tab 20 mg with hydrochlorothiazide 12.5 mg.....	4.92	30	✓	Accuretic 20
Accuretic 20 to be Sole Supply on 1 January 2019				

Angiotensin II Antagonists

CANDESARTAN CILEXETIL				
* Tab 4 mg	1.90	90	✓	Candestar
* Tab 8 mg	2.28	90	✓	Candestar
* Tab 16 mg	3.67	90	✓	Candestar
* Tab 32 mg	6.39	90	✓	Candestar
LOSARTAN POTASSIUM				
* Tab 12.5 mg	1.39	84	✓	Losartan Actavis
* Tab 25 mg	1.63	84	✓	Losartan Actavis
* Tab 50 mg	2.00	84	✓	Losartan Actavis
* Tab 100 mg	2.31	84	✓	Losartan Actavis

Angiotensin II Antagonists with Diuretics

LOSARTAN POTASSIUM WITH HYDROCHLOROTHIAZIDE				
Tab 50 mg with hydrochlorothiazide 12.5 mg.....	1.88	30	✓	Arrow-Losartan & Hydrochlorothiazide

Arrow-Losartan & Hydrochlorothiazide to be Sole Supply on 1 February 2019

Angiotensin II Antagonists with Neprilysin Inhibitors

SACUBITRIL WITH VALSARTAN – Special Authority see SA1751 on the next page – Retail pharmacy				
Note: Due to the angiotensin II receptor blocking activity of sacubitril with valsartan it should not be co-administered with an ACE inhibitor or another ARB.				
Tab 24.3 mg with valsartan 25.7 mg	190.00	56	✓	Entresto 24/26
Tab 48.6 mg with valsartan 51.4 mg	190.00	56	✓	Entresto 49/51
Tab 97.2 mg with valsartan 102.8 mg	190.00	56	✓	Entresto 97/103

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

►SA1751 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:
All of the following:

- 1 Patient has heart failure; and
- 2 Any of the following:
 - 2.1 Patient is in NYHA/WHO functional class II; or
 - 2.2 Patient is in NYHA/WHO functional class III; or
 - 2.3 Patient is in NYHA/WHO functional class IV; and
- 3 Patient has a documented left ventricular ejection fraction (LVEF) of less than or equal to 35%; and
- 4 Patient is receiving concomitant optimal standard chronic heart failure treatments.

Renewal from any relevant practitioner. Approvals valid for 12 months where the treatment remains appropriate and the patient is benefiting from treatment.

Antiarrhythmics

For lignocaine hydrochloride refer to NERVOUS SYSTEM, Anaesthetics, Local, [page 122](#)

AMIODARONE HYDROCHLORIDE

▲ Tab 100 mg – Retail pharmacy-Specialist.....	4.66	30	✓ Cordarone-X
▲ Tab 200 mg – Retail pharmacy-Specialist.....	7.63	30	✓ Cordarone-X
Inj 50 mg per ml, 3 ml ampoule – Up to 5 inj available on a PSO	9.98	5	✓ Lodi

ATROPINE SULPHATE

* Inj 600 mcg per ml, 1 ml ampoule – Up to 5 inj available on a PSO	12.07	10	✓ Martindale
	60.35	50	
	(71.00)		AstraZeneca

Martindale to be Sole Supply on 1 January 2019

(AstraZeneca Inj 600 mcg per ml, 1 ml ampoule to be delisted 1 January 2019)

DIGOXIN

* Tab 62.5 mcg – Up to 30 tab available on a PSO	6.67	240	✓ Lanoxin PG
* Tab 250 mcg – Up to 30 tab available on a PSO	14.52	240	✓ Lanoxin
* Oral liq 50 mcg per ml	16.60	60 ml	✓ Lanoxin
			✓ Lanoxin S29 <small>\$29</small>

DISOPYRAMIDE PHOSPHATE

▲ Cap 100 mg	23.87	100	✓ Rythmodan
--------------------	-------	-----	--------------------

FLECAINIDE ACETATE – Retail pharmacy-Specialist

▲ Tab 50 mg	38.95	60	✓ Tambocor
▲ Cap long-acting 100 mg	38.95	30	✓ Tambocor CR
▲ Cap long-acting 200 mg	68.78	30	✓ Tambocor CR
Inj 10 mg per ml, 15 ml ampoule	52.45	5	✓ Tambocor

MEXILETINE HYDROCHLORIDE

▲ Cap 150 mg	162.00	100	✓ Mexiletine Hydrochloride USP <small>\$29</small>
▲ Cap 250 mg	202.00	100	✓ Mexiletine Hydrochloride USP <small>\$29</small>

PROPAFENONE HYDROCHLORIDE – Retail pharmacy-Specialist

▲ Tab 150 mg	40.90	50	✓ Rytmonorm
--------------------	-------	----	--------------------

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
---	-----	--------------------------	-------------------------------------

Antihypotensives

MIDODRINE – Special Authority see [SA1474 below](#) – Retail pharmacy

Tab 2.5 mg	53.00	100	✓ Gutron
Tab 5 mg	79.00	100	✓ Gutron

► [SA1474](#) Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 2 years where patient has disabling orthostatic hypotension not due to drugs.

Note: Treatment should be started with small doses and titrated upwards as necessary. Hypertension should be avoided, and the usual target is a standing systolic blood pressure of 90 mm Hg.

Renewal from any relevant practitioner. Approvals valid for 2 years where the treatment remains appropriate and the patient is benefiting from treatment.

Beta-Adrenoceptor Blockers

Beta Adrenoceptor Blockers

ATENOLOL

* Tab 50 mg	4.26	500	✓ Mylan Atenolol
* Tab 100 mg	7.30	500	✓ Mylan Atenolol
* Oral liq 25 mg per 5 ml	21.25	300 ml OP	✓ Atenolol AFT

Restricted to children under 12 years of age.

BISOPROLOL FUMARATE

* Tab 2.5 mg	3.53	90	✓ Bosvate
* Tab 5 mg	5.15	90	✓ Bosvate
* Tab 10 mg	9.40	90	✓ Bosvate

CARVEDILOL

* Tab 6.25 mg	2.24	60	✓ Carvedilol Sandoz
* Tab 12.5 mg	2.30	60	✓ Carvedilol Sandoz
* Tab 25 mg	2.95	60	✓ Carvedilol Sandoz

CELIPROLOL

* Tab 200 mg	21.40	180	✓ Celol
--------------------	-------	-----	----------------

LABETALOL

* Tab 50 mg	8.99	100	✓ Hybloc
* Tab 100 mg	11.36	100	✓ Hybloc
* Tab 200 mg	29.74	100	✓ Hybloc
* Inj 5 mg per ml, 20 ml ampoule	59.06	5	
	(88.60)		Trandate

METOPROLOL SUCCINATE

* Tab long-acting 23.75 mg	1.03	30	✓ Betaloc CR
* Tab long-acting 47.5 mg	1.25	30	✓ Betaloc CR
* Tab long-acting 95 mg	1.99	30	✓ Betaloc CR
* Tab long-acting 190 mg	3.00	30	✓ Betaloc CR

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
METOPROLOL TARTRATE				
* Tab 50 mg	5.66	100	✓	Apo-Metoprolol
* Tab 100 mg	7.55	60	✓	Apo-Metoprolol
* Tab long-acting 200 mg.....	23.40	28	✓	Slow-Lopresor
* Inj 1 mg per ml, 5 ml vial.....	24.00	5	✓	Lopresor
	29.50		✓	Metoprolol IV Mylan

Metoprolol IV Mylan to be Sole Supply on 1 February 2019

(Lopresor Inj 1 mg per ml, 5 ml vial to be delisted 1 February 2019)

NADOLOL				
* Tab 40 mg	16.69	100	✓	Apo-Nadolol
* Tab 80 mg	26.43	100	✓	Apo-Nadolol

PINDOLOL				
* Tab 5 mg	13.22	100	✓	Apo-Pindolol
* Tab 10 mg	23.12	100	✓	Apo-Pindolol
* Tab 15 mg	33.31	100	✓	Apo-Pindolol

PROPRANOLOL				
* Tab 10 mg	4.64	100	✓	Apo-Propranolol
* Tab 40 mg	5.72	100	✓	Apo-Propranolol
Cap long-acting 160 mg	18.17	100	✓	Cardinol LA
* Oral liq 4 mg per ml – Special Authority see SA1327 below – Retail pharmacy.....	CBS	500 ml	✓	Roxane S29

➔**SA1327** Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Either:

- 1 For the treatment of a child under 12 years with an haemangioma causing functional impairment (not for cosmetic reasons only); or
- 2 For the treatment of a child under 12 years with cardiac arrhythmias or congenital cardiac abnormalities.

Renewal from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Either:

- 1 For the treatment of a child under 12 years with an haemangioma causing functional impairment (not for cosmetic reasons only); or
- 2 For the treatment of a child under 12 years with cardiac arrhythmias or congenital cardiac abnormalities.

SOTALOL				
* Tab 80 mg	39.53	500	✓	Mylan
* Tab 160 mg	12.48	100	✓	Mylan
TIMOLOL				
* Tab 10 mg	10.55	100	✓	Apo-Timol

Calcium Channel Blockers

Dihydropyridine Calcium Channel Blockers

AMLODIPINE				
* Tab 2.5 mg	1.72	100	✓	Apo-Amlodipine
* Tab 5 mg	3.33	250	✓	Apo-Amlodipine
* Tab 10 mg	4.40	250	✓	Apo-Amlodipine

CARDIOVASCULAR SYSTEM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
FELODIPINE				
* Tab long-acting 2.5 mg.....	1.45	30	✓	Plendil ER
* Tab long-acting 5 mg.....	1.55	30	✓	Plendil ER
	3.93	90	✓	Felo 5 ER
* Tab long-acting 10 mg.....	2.30	30	✓	Plendil ER
	4.32	90	✓	Felo 10 ER
ISRADIPINE				
* Cap long-acting 2.5 mg	7.50	30	✓	Dynacirc-SRO
* Cap long-acting 5 mg	7.85	30	✓	Dynacirc-SRO
<i>(Dynacirc-SRO Cap long-acting 2.5 mg to be delisted 1 February 2019)</i>				
<i>(Dynacirc-SRO Cap long-acting 5 mg to be delisted 1 February 2019)</i>				
NIFEDIPINE				
* Tab long-acting 10 mg.....	10.63	60	✓	Adalat 10
			✓	Adefin ^{S29}
* Tab long-acting 20 mg.....	9.59	100	✓	Nyefax Retard
* Tab long-acting 30 mg.....	3.14	30	✓	Adalat Oros
			✓	Adefin XL
* Tab long-acting 60 mg.....	5.67	30	✓	Adalat Oros

Other Calcium Channel Blockers

DILTIAZEM HYDROCHLORIDE				
* Tab 30 mg	4.60	100	✓	Dilzem
* Tab 60 mg	8.50	100	✓	Dilzem
* Cap long-acting 120 mg	33.42	500	✓	Apo-Diltiazem CD
* Cap long-acting 180 mg	50.05	500	✓	Apo-Diltiazem CD
* Cap long-acting 240 mg	66.76	500	✓	Apo-Diltiazem CD
PERHEXILINE MALEATE				
* Tab 100 mg	62.90	100	✓	Pexsig
VERAPAMIL HYDROCHLORIDE				
* Tab 40 mg	7.01	100	✓	Isoptin
* Tab 80 mg	11.74	100	✓	Isoptin
* Tab long-acting 120 mg.....	15.20	250	✓	Verpamil SR
* Tab long-acting 240 mg.....	25.00	250	✓	Verpamil SR
* Inj 2.5 mg per ml, 2 ml ampoule – Up to 5 inj available on a PSO	25.00	5	✓	Isoptin

Centrally-Acting Agents

CLONIDINE				
* Patch 2.5 mg, 100 mcg per day – Only on a prescription.....	7.40	4	✓	Mylan
* Patch 5 mg, 200 mcg per day – Only on a prescription.....	10.04	4	✓	Mylan
* Patch 7.5 mg, 300 mcg per day – Only on a prescription.....	12.34	4	✓	Mylan
CLONIDINE HYDROCHLORIDE				
* Tab 25 mcg.....	8.75	112	✓	Clonidine BNM
* Tab 150 mcg.....	34.32	100	✓	Catapres
* Inj 150 mcg per ml, 1 ml ampoule	25.96	10	✓	Medsurge
	12.98	5		
	(16.07)			Catapres

Medsurge to be Sole Supply on 1 January 2019

(Catapres Inj 150 mcg per ml, 1 ml ampoule to be delisted 1 January 2019)

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
METHYLDOPA				
* Tab 250 mg	15.10	100	✓	Methyldopa Mylan

Diuretics

Loop Diuretics

BUMETANIDE				
* Tab 1 mg	16.36	100	✓	Burinex
* Inj 500 mcg per ml, 4 ml vial.....	7.95	5	✓	Burinex
FUROSEMIDE [FRUSEMIDE]				
* Tab 40 mg – Up to 30 tab available on a PSO	8.00	1,000	✓	Diurin 40
* Tab 500 mg	25.00	50	✓	Urex Forte
* Oral liq 10 mg per ml	10.66	30 ml OP	✓	Lasix
* Inj 10 mg per ml, 25 ml ampoule.....	57.77	6	✓	Lasix
* Inj 10 mg per ml, 2 ml ampoule – Up to 5 inj available on a PSO	1.20	5	✓	Frusemide-Clarix

Potassium Sparing Diuretics

AMILORIDE HYDROCHLORIDE				
* Tab 5 mg	15.00	100	✓	Apo-Amiloride
Oral liq 1 mg per ml	30.00	25 ml OP	✓	Biomed
<i>(Apo-Amiloride Tab 5 mg to be delisted 1 January 2019)</i>				
EPLERENONE – Special Authority see SA1728 below – Retail pharmacy				
Tab 50 mg	17.00	30	✓	Inspira
Inspira to be Sole Supply on 1 January 2019				
Tab 25 mg	11.87	30	✓	Inspira

►SA1728 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- 1 Patient has heart failure with ejection fraction less than 40%; and
- 2 Either:
 - 2.1 Patient is intolerant to optimal dosing of spironolactone; or
 - 2.2 Patient has experienced a clinically significant adverse effect while on optimal dosing of spironolactone.

METOLAZONE – Special Authority see [SA1678 below](#) – Retail pharmacy

Tab 5 mg	CBS	1	✓	Metolazone ^{S29}
		50	✓	Zaroxolyn ^{S29}

►SA1678 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Either:

- 1 Patient has refractory heart failure and is intolerant or has not responded to loop diuretics and/or loop-thiazide combination therapy; or
- 2 Paediatric patient has oedema secondary to nephrotic syndrome that has not responded to loop diuretics.

SPIRONOLACTONE

* Tab 25 mg	4.38	100	✓	Spiractin
* Tab 100 mg	11.80	100	✓	Spiractin
Oral liq 5 mg per ml	30.00	25 ml OP	✓	Biomed

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
Potassium Sparing Combination Diuretics				
AMILORIDE HYDROCHLORIDE WITH FUROSEMIDE				
* Tab 5 mg with furosemide 40 mg	8.63	28	✓	Frumil
AMILORIDE HYDROCHLORIDE WITH HYDROCHLOROTHIAZIDE				
* Tab 5 mg with hydrochlorothiazide 50 mg	5.00	50	✓	Moduretic
Thiazide and Related Diuretics				
BENDROFLUMETHIAZIDE [BENDROFLUAZIDE]				
* Tab 2.5 mg – Up to 150 tab available on a PSO	12.50	500	✓	Arrow- Bendrofluaizide
May be supplied on a PSO for reasons other than emergency.				
* Tab 5 mg	20.42	500	✓	Arrow- Bendrofluaizide
CHLOROTHIAZIDE				
Oral liq 50 mg per ml	26.00	25 ml OP	✓	Biomed
CHLORTALIDONE [CHLORTHALIDONE]				
* Tab 25 mg	8.00	50	✓	Hygroton
INDAPAMIDE				
* Tab 2.5 mg	2.60	90	✓	Dapa-Tabs
Lipid-Modifying Agents				
Fibrates				
BEZAFIBRATE				
* Tab 200 mg	19.01	90	✓	Bezalip
Bezalip to be Sole Supply on 1 January 2019				
* Tab long-acting 400 mg	12.89	30	✓	Bezalip Retard
Bezalip Retard to be Sole Supply on 1 January 2019				
GEMFIBROZIL				
* Tab 600 mg	19.56	60	✓	Lipazil
Other Lipid-Modifying Agents				
ACIPIMOX				
* Cap 250 mg	18.75	30	✓	Olbetam
NICOTINIC ACID				
* Tab 50 mg	4.12	100	✓	Apo-Nicotinic Acid
* Tab 500 mg	17.89	100	✓	Apo-Nicotinic Acid

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
Resins				
CHOLESTYRAMINE				
Powder for oral liq 4 g	19.25 (52.68) (52.68)	50		Questran-Lite Questran-Lite S29 S29

(Questran-Lite Powder for oral liq 4 g to be delisted 1 June 2019)

(Questran-Lite S29 ~~S29~~ Powder for oral liq 4 g to be delisted 1 June 2019)

COLESTIPOL HYDROCHLORIDE				
Grans for oral liq 5 g	28.60	30	✓	Colestid

HMG CoA Reductase Inhibitors (Statins)

Prescribing Guidelines

Treatment with HMG CoA Reductase Inhibitors (statins) is recommended for patients with dyslipidaemia and an absolute 5 year cardiovascular risk of 15% or greater.

ATORVASTATIN – See prescribing guideline [above](#)

* Tab 10 mg	6.96	500	✓	<u>Lorstat</u>
* Tab 20 mg	9.99	500	✓	<u>Lorstat</u>
* Tab 40 mg	15.93	500	✓	<u>Lorstat</u>
* Tab 80 mg	27.19	500	✓	<u>Lorstat</u>

PRAVASTATIN – See prescribing guideline [above](#)

* Tab 20 mg	4.72	100	✓	<u>Apo-Pravastatin</u>
* Tab 40 mg	8.06	100	✓	<u>Apo-Pravastatin</u>

SIMVASTATIN – See prescribing guideline [above](#)

* Tab 10 mg	0.95	90	✓	<u>Simvastatin Mylan</u>
* Tab 20 mg	1.52	90	✓	<u>Simvastatin Mylan</u>
* Tab 40 mg	2.63	90	✓	<u>Simvastatin Mylan</u>
* Tab 80 mg	6.00	90	✓	<u>Simvastatin Mylan</u>

Selective Cholesterol Absorption Inhibitors

EZETIMIBE – Special Authority see [SA1045 below](#) – Retail pharmacy

* Tab 10 mg	2.00	30	✓	<u>Ezetimibe Sandoz</u>
-------------------	------	----	---	-------------------------

►SA1045 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

All of the following:

- 1 Patient has a calculated absolute risk of cardiovascular disease of at least 15% over 5 years; and
- 2 Patient's LDL cholesterol is 2.0 mmol/litre or greater; and
- 3 Any of the following:
 - 3.1 The patient has rhabdomyolysis (defined as muscle aches and creatine kinase more than 10 × normal) when treated with one statin; or
 - 3.2 The patient is intolerant to both simvastatin and atorvastatin; or
 - 3.3 The patient has not reduced their LDL cholesterol to less than 2.0 mmol/litre with the use of the maximal tolerated dose of atorvastatin.

Notes: A patient who has failed to reduce their LDL cholesterol to < 2.0 mmol/litre with the use of a less potent statin should use a more potent statin prior to consideration being given to the use of non-statin therapies.

continued...

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

Other treatment options including fibrates, resins and nicotinic acid should be considered after failure of statin therapy. If a patient's LDL cholesterol cannot be calculated because the triglyceride level is too high then a repeat test should be performed and if the LDL cholesterol again cannot be calculated then it can be considered that the LDL cholesterol is greater than 2.0 mmol/litre.

Renewal from any relevant practitioner. Approvals valid for 2 years where the treatment remains appropriate and the patient is benefiting from treatment.

EZETIMIBE WITH SIMVASTATIN – Special Authority see [SA1046 below](#) – Retail pharmacy

Tab 10 mg with simvastatin 10 mg	5.15	30	✓ Zimybe
Tab 10 mg with simvastatin 20 mg	6.15	30	✓ Zimybe
Tab 10 mg with simvastatin 40 mg	7.15	30	✓ Zimybe
Tab 10 mg with simvastatin 80 mg	8.15	30	✓ Zimybe

► **SA1046** Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

All of the following:

- 1 Patient has a calculated absolute risk of cardiovascular disease of at least 15% over 5 year; and
- 2 Patient's LDL cholesterol is 2.0 mmol/litre or greater; and
- 3 The patient has not reduced their LDL cholesterol to less than 2.0 mmol/litre with the use of the maximal tolerated dose of atorvastatin.

Notes: A patient who has failed to reduce their LDL cholesterol to less than or equal to 2.0 mmol/litre with the use of a less potent statin should use a more potent statin prior to consideration being given to the use of non-statin therapies.

Other treatment options including fibrates, resins and nicotinic acid should be considered after failure of statin therapy.

If a patient's LDL cholesterol cannot be calculated because the triglyceride level is too high then a repeat test should be performed and if the LDL cholesterol again cannot be calculated then it can be considered that the LDL cholesterol is greater than 2.0 mmol/litre.

Renewal from any relevant practitioner. Approvals valid for 2 years where the treatment remains appropriate and the patient is benefiting from treatment.

Nitrates

GLYCERYL TRINITRATE

* Tab 600 mcg – Up to 100 tab available on a PSO	8.00	100 OP	✓ Lycinate
* Oral pump spray, 400 mcg per dose – Up to 250 dose available on a PSO	4.45	250 dose OP	✓ Nitrolingual Pump Spray
* Oral spray, 400 mcg per dose – Up to 200 dose available on a PSO	4.45	200 dose OP	✓ Glytrin
* Patch 25 mg, 5 mg per day	15.73	30	✓ Nitroderm TTS
* Patch 50 mg, 10 mg per day	18.62	30	✓ Nitroderm TTS

ISOSORBIDE MONONITRATE

* Tab 20 mg	18.80	100	✓ Ismo 20
* Tab long-acting 40 mg	7.50	30	✓ Ismo 40 Retard
* Tab long-acting 60 mg	8.29	90	✓ Duride

Sympathomimetics

ADRENALINE

Inj 1 in 1,000, 1 ml ampoule – Up to 5 inj available on a PSO	4.98	5	✓ Aspen Adrenaline
	5.25		✓ Hospira
Inj 1 in 10,000, 10 ml ampoule – Up to 5 inj available on a PSO	27.00	5	✓ Hospira
	49.00	10	✓ Aspen Adrenaline

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
ISOPRENALINE [ISOPROTERENOL]				
* Inj 200 mcg per ml, 1 ml ampoule	36.80 (164.20)	25		Isuprel

Vasodilators

HYDRALAZINE HYDROCHLORIDE

* Tab 25 mg – Special Authority see SA1321 below – Retail pharmacy.....	CBS	1	✓ Hydralazine
		56	✓ Onelink ^{\$29}
		84	✓ AMDIPHARM ^{\$29}
		100	✓ Onelink ^{\$29}
* Inj 20 mg ampoule	25.90	5	✓ Apresoline

►SA1321 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Either:

- 1 For the treatment of refractory hypertension; or
- 2 For the treatment of heart failure in combination with a nitrate, in patients who are intolerant or have not responded to ACE inhibitors and/or angiotensin receptor blockers.

MINOXIDIL

▲ Tab 10 mg	70.00	100	✓ Loniten
-------------------	-------	-----	-----------

NICORANDIL

▲ Tab 10 mg	27.95	60	✓ Ikorel
▲ Tab 20 mg	33.28	60	✓ Ikorel

PAPAVERINE HYDROCHLORIDE

* Inj 12 mg per ml, 10 ml ampoule	217.90	5	✓ Hospira
---	--------	---	-----------

PENTOXIFYLLINE [OXPENTIFYLLINE]

Tab 400 mg	42.26	50	✓ Trental 400
------------------	-------	----	---------------

Endothelin Receptor Antagonists

AMBRISENTAN – Special Authority see [SA1702 below](#) – Retail pharmacy

Tab 5 mg	4,585.00	30	✓ Volibris
Tab 10 mg	4,585.00	30	✓ Volibris

►SA1702 Special Authority for Subsidy

Special Authority approved by the Pulmonary Arterial Hypertension Panel

Notes: Application details may be obtained from PHARMAC's website <http://www.pharmac.govt.nz> or:

The Coordinator, PAH Panel

PHARMAC, PO Box 10-254, WELLINGTON

Tel: (04) 916 7561, Fax: (04) 974 4858, Email: PAH@pharmac.govt.nz

BOSENTAN – Special Authority see [SA1712 on the next page](#) – Retail pharmacy

Tab 62.5 mg	141.00	60	✓ Bosentan Dr Reddy's
	401.79		✓ Bosentan-Mylan
Tab 125 mg	141.00	60	✓ Bosentan Dr Reddy's
	401.79		✓ Bosentan-Mylan

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

►SA1712 Special Authority for Subsidy

Initial application only from a respiratory specialist, cardiologist or medical practitioner on the recommendation of a respiratory physician or cardiologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has pulmonary arterial hypertension (PAH)*; and
- 2 PAH is in Group 1, 4 or 5 of the WHO (Venice) clinical classifications; and
- 3 PAH is at NYHA/WHO functional class II, III, or IV; and
- 4 Any of the following:
 - 4.1 Both:
 - 4.1.1 Bosentan is to be used as PAH monotherapy; and
 - 4.1.2 Either:
 - 4.1.2.1 Patient is intolerant or contraindicated to sildenafil; or
 - 4.1.2.2 Patient is a child with idiopathic PAH or PAH secondary to congenital heart disease; or
 - 4.2 Both:
 - 4.2.1 Bosentan is to be used as PAH dual therapy; and
 - 4.2.2 Either:
 - 4.2.2.1 Patient has tried a PAH monotherapy for at least three months and failed to respond; or
 - 4.2.2.2 Patient deteriorated while on a PAH monotherapy; or
 - 4.3 Both:
 - 4.3.1 Bosentan is to be used as PAH triple therapy; and
 - 4.3.2 Any of the following:
 - 4.3.2.1 Patient is on the lung transplant list; or
 - 4.3.2.2 Patient is presenting acutely with idiopathic pulmonary arterial hypertension (IPAH) in New York Heart Association/World Health Organization (NYHA/WHO) Functional Class IV; or
 - 4.3.2.3 Patient is deteriorating rapidly to NYHA/WHO Functional Class IV who may be lung transplant recipients in the future, if their disease is stabilised; or
 - 4.3.2.4 Patient has PAH associated with the scleroderma spectrum of diseases (APAHSSD) who have no major morbidities and are deteriorating despite combination therapy.

Renewal only from a respiratory specialist, cardiologist or medical practitioner on the recommendation of a respiratory physician or cardiologist. Approvals valid for 2 years for applications meeting the following criteria:

Any of the following:

- 1 Both:
 - 1.1 Bosentan is to be used as PAH monotherapy; and
 - 1.2 Patient is stable or has improved while on bosentan; or
- 2 Both:
 - 2.1 Bosentan is to be used as PAH dual therapy; and
 - 2.2 Patient has tried a PAH monotherapy for at least three months and either failed to respond or later deteriorated; or
- 3 Both:
 - 3.1 Bosentan is to be used as PAH triple therapy; and
 - 3.2 Any of the following:
 - 3.2.1 Patient is on the lung transplant list; or
 - 3.2.2 Patient is presenting acutely with idiopathic pulmonary arterial hypertension (IPAH) in New York Heart Association/World Health Organization (NYHA/WHO) Functional Class IV; or
 - 3.2.3 Patient is deteriorating rapidly to NYHA/WHO Functional Class IV who may be lung transplant recipients in the future, if their disease is stabilised; or
 - 3.2.4 Patient has PAH associated with the scleroderma spectrum of diseases (APAHSSD) who have no major morbidities and are deteriorating despite combination therapy.

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

Phosphodiesterase Type 5 Inhibitors

SILDENAFIL – Special Authority see [SA1738 below](#) – Retail pharmacy

Tab 25 mg	0.64	4	✓ Vedafil
Tab 50 mg	0.64	4	✓ Vedafil
Tab 100 mg	6.60	12	✓ Vedafil

Vedafil to be Sole Supply on 1 December 2018

►SA1738 Special Authority for Subsidy

Initial application — (Raynaud's Phenomenon*) from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 Patient has Raynaud's Phenomenon*; and
- 2 Patient has severe digital ischaemia (defined as severe pain requiring hospital admission or with a high likelihood of digital ulceration; digital ulcers; or gangrene); and
- 3 Patient is following lifestyle management (avoidance of cold exposure, sufficient protection, smoking cessation support, avoidance of sympathomimetic drugs); and
- 4 Patient is being treated with calcium channel blockers and nitrates (or these are contraindicated/not tolerated).

Initial application — (Pulmonary arterial hypertension*) only from a respiratory specialist, cardiologist or medical practitioner on the recommendation of a respiratory specialist or cardiologist. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 Patient has pulmonary arterial hypertension (PAH)*; and
- 2 Any of the following:
 - 2.1 PAH is in Group 1 of the WHO (Venice) clinical classifications; or
 - 2.2 PAH is in Group 4 of the WHO (Venice) clinical classifications; or
 - 2.3 PAH is in Group 5 of the WHO (Venice) clinical classifications; and
- 3 Any of the following:
 - 3.1 PAH is in NYHA/WHO functional class II; or
 - 3.2 PAH is in NYHA/WHO functional class III; or
 - 3.3 PAH is in NYHA/WHO functional class IV; and
- 4 Either:
 - 4.1 All of the following:
 - 4.1.1 Patient has a pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg; and
 - 4.1.2 Either:
 - 4.1.2.1 Patient has a mean pulmonary artery pressure (PAPm) > 25 mmHg; or
 - 4.1.2.2 Patient is peri Fontan repair; and
 - 4.1.3 Patient has a pulmonary vascular resistance (PVR) of at least 3 Wood Units or at least 240 International Units (dyn s cm⁻⁵); or
 - 4.2 Testing for PCWP, PAPm, or PVR cannot be performed due to the patient's young age.

Note: Indications marked with * are unapproved indications.

Prostacyclin Analogues

EPOPSTENOL – Special Authority see [SA1696 on the next page](#) – Retail pharmacy

Inj 500 mcg vial.....	36.61	1	✓ Velettri
Inj 1.5 mcg vial	73.21	1	✓ Velettri

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
--	---	----------------------------	-------------------------------------

►SA1696 Special Authority for Subsidy

Special Authority approved by the Pulmonary Arterial Hypertension Panel

Notes: Application details may be obtained from PHARMAC's website <http://www.pharmac.govt.nz> or:

The Coordinator, PAH Panel

PHARMAC, PO Box 10-254, WELLINGTON

Tel: (04) 916 7561, Fax: (04) 974 4858, Email: PAH@pharmac.govt.nz

ILOPROST – Special Authority see SA1705 below – Retail pharmacy

Nebuliser soln 10 mcg per ml, 2 ml	1,185.00	30	✓ Ventavis
--	----------	----	------------

►SA1705 Special Authority for Subsidy

Special Authority approved by the Pulmonary Arterial Hypertension Panel

Notes: Application details may be obtained from PHARMAC's website <http://www.pharmac.govt.nz> or:

The Coordinator, PAH Panel

PHARMAC, PO Box 10-254, WELLINGTON

Tel: (04) 916 7561, Fax: (04) 974 4858, Email: PAH@pharmac.govt.nz

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

Antiacne Preparations

For systemic antibacterials, refer to INFECTIONS, Antibacterials, [page 50](#)

ADAPALENE

- Maximum of 30 g per prescription
- Only on a prescription

Crm 0.1%.....	22.89	30 g OP	✓ Differin
Gel 0.1%.....	22.89	30 g OP	✓ Differin

ISOTRETINOIN – Special Authority see [SA1475 below](#) – Retail pharmacy

Cap 5 mg.....	8.14	60	✓ Oratane
Cap 10 mg.....	13.34	120	✓ Oratane
	11.12	100	
	(12.47)		Isotane 10
Oratane to be Sole Supply on 1 January 2019			
Cap 20 mg.....	17.08	100	✓ Isotane 20
	20.49	120	✓ Oratane

Oratane to be Sole Supply on 1 January 2019

(Isotane 10 Cap 10 mg to be delisted 1 January 2019)

(Isotane 20 Cap 20 mg to be delisted 1 January 2019)

►SA1475 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 1 year for applications meeting the following criteria:

All of the following:

- Applicant is a vocationally registered dermatologist, vocationally registered general practitioner, or nurse practitioner working in a relevant scope of practice; and
- Applicant has an up to date knowledge of the safety issues around isotretinoin and is competent to prescribe isotretinoin; and
- Either:
 - 3.1 Patient is female and has been counselled and understands the risk of teratogenicity if isotretinoin is used during pregnancy and the applicant has ensured that the possibility of pregnancy has been excluded prior to the commencement of the treatment and that the patient is informed that she must not become pregnant during treatment and for a period of one month after the completion of the treatment; or
 - 3.2 Patient is male.

Note: Applicants are recommended to either have used or be familiar with using a decision support tool accredited by their professional body.

Renewal from any relevant practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Either:

- 1 Patient is female and has been counselled and understands the risk of teratogenicity if isotretinoin is used during pregnancy and the applicant has ensured that the possibility of pregnancy has been excluded prior to the commencement of the treatment and that the patient is informed that she must not become pregnant during treatment and for a period of one month after the completion of the treatment; or
- 2 Patient is male.

Note: Applicants are recommended to either have used or be familiar with using a decision support tool accredited by their professional body.

TRETINOIN

Crm 0.5 mg per g – Maximum of 50 g per prescription	13.90	50 g OP	✓ ReTrieve
---	-------	---------	------------

Antibacterials Topical

For systemic antibacterials, refer to INFECTIONS, Antibacterials, [page 90](#)

HYDROGEN PEROXIDE

* Crm 1%.....	8.56	15 g OP	✓ Crystaderm
---------------	------	---------	---------------------

MUPIROCIN

Oint 2%.....	6.60 (9.26)	15 g OP	Bactroban
a) Only on a prescription			
b) Not in combination			

SODIUM FUSIDATE [FUSIDIC ACID]

Crm 2%.....	2.52	15 g OP	✓ DP Fusidic Acid Cream
-------------	------	---------	--------------------------------

- a) Maximum of 15 g per prescription
- b) Only on a prescription
- c) Not in combination

Oint 2%.....	3.45	15 g OP	✓ Foban
a) Maximum of 15 g per prescription			
b) Only on a prescription			
c) Not in combination			

SULFADIAZINE SILVER

Crm 1%.....	10.80	50 g OP	✓ Flamazine
a) Up to 250 g available on a PSO			
b) Not in combination			

Antifungals Topical

For systemic antifungals, refer to INFECTIONS, Antifungals, [page 97](#)

AMOROLFINE

a) Only on a prescription			
b) Not in combination			
Nail soln 5%.....	15.95	5 ml OP	✓ MycoNail

CICLOPIROX OLAMINE

a) Only on a prescription			
b) Not in combination			
Nail-soln 8%	5.72	7 ml OP	✓ Apo-Ciclopirox

CLOTRIMAZOLE

* Crm 1%.....	0.70	20 g OP	✓ Clomazol
a) Only on a prescription			
b) Not in combination			

* Soln 1%	4.36 (7.55)	20 ml OP	Canesten
a) Only on a prescription			
b) Not in combination			

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
ECONAZOLE NITRATE				
Crm 1%.....	1.00 (7.48)	20 g OP		Pevaryl
a) Only on a prescription				
b) Not in combination				
Foaming soln 1%, 10 ml sachets.....	9.89 (17.23)	3		Pevaryl
a) Only on a prescription				
b) Not in combination				
MICONAZOLE NITRATE				
* Crm 2%.....	0.74	15 g OP	✓	Multichem
a) Only on a prescription				
b) Not in combination				
* Lotn 2%	4.36 (10.03)	30 ml OP		Daktarin
a) Only on a prescription				
b) Not in combination				
* Tinct 2%.....	4.36 (12.10)	30 ml OP		Daktarin
a) Only on a prescription				
b) Not in combination				
NYSTATIN				
Crm 100,000 u per g.....	1.00 (7.90)	15 g OP		Mycostatin
a) Only on a prescription				
b) Not in combination				
Antipruritic Preparations				
CALAMINE				
a) Only on a prescription				
b) Not in combination				
Crm, aqueous, BP	1.26 (1.49)	100 g	✓	healthE Calamine Aqueous Cream BP Pharmacy Health
healthE Calamine Aqueous Cream BP to be Sole Supply on 1 February 2019				
Lotn, BP	12.94	2,000 ml	✓	PSM
<i>(Pharmacy Health Crm, aqueous, BP to be delisted 1 February 2019)</i>				
CROTAMITON				
a) Only on a prescription				
b) Not in combination				
Crm 10%.....	3.29	20 g OP	✓	Itch-Soothe
MENTHOL – Only in combination				
1) Only in combination with a dermatological base or proprietary Topical Corticosteroid – Plain				
2) With or without other dermatological galenicals.				
Crystals.....	6.92 29.60	25 g 100 g	✓ ✓	MidWest MidWest

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

Corticosteroids Topical

For systemic corticosteroids, refer to CORTICOSTEROIDS AND RELATED AGENTS, page 79

Corticosteroids - Plain

BETAMETHASONE DIPROPIONATE

Crm 0.05%.....	2.96	15 g OP	✓ Diprosone
	8.97	50 g OP	✓ Diprosone
Crm 0.05% in propylene glycol base	4.33	30 g OP	✓ Diprosone OV
Oint 0.05%.....	2.96	15 g OP	✓ Diprosone
	8.97	50 g OP	✓ Diprosone
Oint 0.05% in propylene glycol base	4.33	30 g OP	✓ Diprosone OV

BETAMETHASONE VALERATE

* Crm 0.1%.....	3.45	50 g OP	✓ Beta Cream
* Oint 0.1%.....	3.45	50 g OP	✓ Beta Ointment
* Lotn 0.1%	18.00	50 ml OP	✓ Betnovate

Betnovate to be Sole Supply on 1 January 2019

CLOBETASOL PROPIONATE

* Crm 0.05%.....	2.20	30 g OP	✓ Dermol
* Oint 0.05%.....	2.20	30 g OP	✓ Dermol

CLOBETASONE BUTYRATE

Crm 0.05%.....	5.38	30 g OP	
	(7.09)		Eumovate

DIFLUCORTOLONE VALERATE

Crm 0.1%.....	8.97	50 g OP	
	(15.86)		Nerisone
Fatty oint 0.1%.....	8.97	50 g OP	
	(15.86)		Nerisone

HYDROCORTISONE

* Crm 1% – Only on a prescription.....	1.11	30 g OP	✓ DermAssist
	16.25	500 g	✓ Pharmacy Health
* Powder – Only in combination.....	49.95	25 g	✓ ABM

Up to 5% in a dermatological base (not proprietary Topical Corticosteroid – Plain) with or without other dermatological galenicals

HYDROCORTISONE AND PARAFFIN LIQUID AND LANOLIN

Lotn 1% with paraffin liquid 15.9% and lanolin 0.6% – Only on a prescription	10.57	250 ml	✓ DP Lotn HC
--	-------	--------	---------------------

HYDROCORTISONE BUTYRATE

Lipocream 0.1%.....	2.30	30 g OP	✓ Locoid Lipocream
	6.85	100 g OP	✓ Locoid Lipocream
Oint 0.1%.....	6.85	100 g OP	✓ Locoid
Milky emul 0.1%	6.85	100 ml OP	✓ Locoid Crelo

METHYLPREDNISOLONE ACEPONATE

Crm 0.1%.....	4.95	15 g OP	✓ Advantan
Oint 0.1%.....	4.95	15 g OP	✓ Advantan

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
MOMETASONE FUROATE				
Crm 0.1%.....	1.51	15 g OP	✓	Elocon Alcohol Free
	2.50	50 g OP	✓	Elocon Alcohol Free
Elocon Alcohol Free to be Sole Supply on 1 December 2018				
Oint 0.1%.....	1.51	15 g OP	✓	Elocon
	2.90	50 g OP	✓	Elocon
Elocon to be Sole Supply on 1 December 2018				
Lotn 0.1%	6.30	30 ml OP	✓	Elocon
Elocon to be Sole Supply on 1 December 2018				
TRIAMCINOLONE ACETONIDE				
Crm 0.02%.....	6.30	100 g OP	✓	Aristocort
Oint 0.02%.....	6.35	100 g OP	✓	Aristocort

Corticosteroids - Combination

BETAMETHASONE VALERATE WITH CLIOQUINOL – Only on a prescription				
Crm 0.1% with clioquinol 3%.....	3.49 (4.90)	15 g OP		Betnovate-C
BETAMETHASONE VALERATE WITH SODIUM FUSIDATE [FUSIDIC ACID]				
Crm 0.1% with sodium fusidate (fusidic acid) 2%.....	3.49 (10.45)	15 g OP		Fucicort
a) Maximum of 15 g per prescription				
b) Only on a prescription				
HYDROCORTISONE WITH MICONAZOLE – Only on a prescription				
* Crm 1% with miconazole nitrate 2%.....	2.00	15 g OP	✓	Micreme H
HYDROCORTISONE WITH NATAMYCIN AND NEOMYCIN – Only on a prescription				
Crm 1% with natamycin 1% and neomycin sulphate 0.5%	2.79	15 g OP	✓	Pimafucort
Oint 1% with natamycin 1% and neomycin sulphate 0.5%.....	2.79	15 g OP	✓	Pimafucort
TRIAMCINOLONE ACETONIDE WITH GRAMICIDIN, NEOMYCIN AND NYSTATIN				
Crm 1 mg with nystatin 100,000 u, neomycin sulphate 2.5 mg and gramicidin 250 mcg per g – Only on a prescription	3.49 (6.60)	15 g OP		Viaderm KC

Disinfecting and Cleansing Agents

CHLORHEXIDINE GLUCONATE – Subsidy by endorsement				
a) No more than 500 ml per month				
b) Only if prescribed for a dialysis patient and the prescription is endorsed accordingly.				
* Handrub 1% with ethanol 70%.....	4.29	500 ml	✓	healthE
* Soln 4% wash.....	3.98	500 ml	✓	healthE
TRICLOSAN – Subsidy by endorsement				
a) Maximum of 500 ml per prescription				
b)				
a) Only if prescribed for a patient identified with Methicillin-resistant Staphylococcus aureus (MRSA) prior to elective surgery in hospital and the prescription is endorsed accordingly; or				
b) Only if prescribed for a patient with recurrent Staphylococcus aureus infection and the prescription is endorsed accordingly				
Soln 1%	5.90	500 ml OP	✓	healthE

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
Barrier Creams and Emollients				
Barrier Creams				
DIMETHICONE				
* Crm 5% pump bottle.....	4.59	500 ml OP	✓	<u>healthE</u> <u>Dimethicone 5%</u>
* Crm 10% pump bottle.....	4.52	500 ml OP	✓	<u>healthE</u> <u>Dimethicone 10%</u>
ZINC AND CASTOR OIL				
* Oint.....	4.25	500 g	✓	<u>Boucher</u>
Emollients				
AQUEOUS CREAM				
* Crm.....	1.92	500 g	✓	<u>Boucher</u>
	1.99		✓	<u>AFT SLS-free</u>
			✓	<u>Home Essentials</u>
<i>(Home Essentials Crm to be delisted 1 December 2018)</i>				
CETOMACROGOL				
* Crm BP.....	2.48	500 g	✓	<u>healthE</u>
CETOMACROGOL WITH GLYCEROL				
Crm 90% with glycerol 10%.....	2.82	500 ml OP	✓	<u>Pharmacy Health</u> <u>Sorbolene with</u> <u>Glycerin</u>
	3.87	1,000 ml OP	✓	<u>Pharmacy Health</u> <u>Sorbolene with</u> <u>Glycerin</u>
EMULSIFYING OINTMENT				
Oint BP.....	3.59	500 g	✓	<u>AFT</u>
OIL IN WATER EMULSION				
* Crm.....	2.19	500 g	✓	<u>O/W Fatty Emulsion</u> <u>Cream</u>
O/W Fatty Emulsion Cream to be Sole Supply on 1 February 2019				
PARAFFIN				
Oint liquid paraffin 50% with white soft paraffin 50%.....	5.35	500 ml OP	✓	<u>healthE</u>
healthE to be Sole Supply on 1 February 2019				
UREA				
* Crm 10%.....	1.37	100 g OP	✓	<u>healthE Urea Cream</u>
WOOL FAT WITH MINERAL OIL – Only on a prescription				
* Lotn hydrous 3% with mineral oil.....	5.60	1,000 ml		DP Lotion
	(11.95)			
	1.40	250 ml OP		DP Lotion
	(4.53)			
	5.60	1,000 ml		DP Lotion
	(20.53)			Alpha-Keri Lotion
	(23.91)			BK Lotion
	1.40	250 ml OP		BK Lotion
	(7.73)			

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

Other Dermatological Bases

PARAFFIN

White soft – Only in combination	20.20	2,500 g	✓ IPW
	3.58	500 g	
	(7.78)		IPW
	(8.69)		PSM

Only in combination with a dermatological galenical or as a diluent for a proprietary Topical Corticosteroid – Plain.

Minor Skin Infections

POVIDONE IODINE

Oint 10%	3.27	25 g OP	✓ Betadine
a) Maximum of 100 g per prescription			
b) Only on a prescription			
Antiseptic soln 10%	6.20	500 ml	✓ Betadine
			✓ Riiodine
	1.28	100 ml	
	(4.20)		Riiodine
	(13.27)		Betadine
	0.19	15 ml	
	(7.41)		Betadine
Skin preparation, povidone iodine 10% with 30% alcohol	10.00	500 ml	✓ Betadine Skin Prep
	1.63	100 ml	
	(3.48)		Betadine Skin Prep
Skin preparation, povidone iodine 10% with 70% alcohol	1.63	100 ml	
	(6.04)		Orion
	(6.64)		Pfizer

(Orion Skin preparation, povidone iodine 10% with 70% alcohol to be delisted 1 June 2019)

Parasitocidal Preparations

DIMETHICONE

* Lotn 4%	4.98	200 ml OP	✓ <u>healthE</u> <u>Dimethicone 4%</u> <u>Lotion</u>
-----------------	------	-----------	--

IVERMECTIN – Special Authority see [SA1225 below](#) – Retail pharmacy

Tab 3 mg – Up to 100 tab available on a PSO	17.20	4	✓ Stromectol
---	-------	---	--------------

- 1) PSO for institutional use only. Must be endorsed with the name of the institution for which the PSO is required and a valid Special Authority for patient of that institution.
- 2) Ivermectin available on BSO provided the BSO includes a valid Special Authority for a patient of the institution.
- 3) For the purposes of subsidy of ivermectin, institution means age related residential care facilities, disability care facilities or penal institutions.

»SA1225 Special Authority for Subsidy

Initial application — (Scabies) from any relevant practitioner. Approvals valid for 1 month for applications meeting the following criteria:

Both:

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

- 1 Applying clinician has discussed the diagnosis of scabies with a dermatologist, infectious disease physician or clinical microbiologist; and
- 2 Either:
 - 2.1 Both:
 - 2.1.1 The patient is in the community; and
 - 2.1.2 Any of the following:
 - 2.1.2.1 Patient has a severe scabies hyperinfestation (Crusted/ Norwegian scabies); or
 - 2.1.2.2 The community patient is physically or mentally unable to comply with the application instructions of topical therapy; or
 - 2.1.2.3 The patient has previously tried and failed to clear infestation using topical therapy; or
 - 2.2 All of the following:
 - 2.2.1 The Patient is a resident in an institution; and
 - 2.2.2 All residents of the institution with scabies or at risk of carriage are to be treated for scabies concurrently; and
 - 2.2.3 Any of the following:
 - 2.2.3.1 Patient has a severe scabies hyperinfestation (Crusted/ Norwegian scabies); or
 - 2.2.3.2 The patient is physically or mentally unable to comply with the application instructions of topical therapy; or
 - 2.2.3.3 Previous topical therapy has been tried and failed to clear the infestation.

Note: Ivermectin is no more effective than topical therapy for treatment of standard scabies infestation.

Initial application — (Other parasitic infections) only from an infectious disease specialist, clinical microbiologist or dermatologist. Approvals valid for 1 month for applications meeting the following criteria:

Any of the following:

- 1 Filaricides; or
- 2 Cutaneous larva migrans (creeping eruption); or
- 3 Strongyloidiasis.

Renewal — (Scabies) from any relevant practitioner. Approvals valid for 1 month for applications meeting the following criteria: Both:

- 1 Applying clinician has discussed the diagnosis of scabies with a dermatologist, infectious disease physician or clinical microbiologist; and
- 2 Either:
 - 2.1 Both:
 - 2.1.1 The patient is in the community; and
 - 2.1.2 Any of the following:
 - 2.1.2.1 Patient has a severe scabies hyperinfestation (Crusted/ Norwegian scabies); or
 - 2.1.2.2 The community patient is physically or mentally unable to comply with the application instructions of topical therapy; or
 - 2.1.2.3 The patient has previously tried and failed to clear infestation using topical therapy; or
 - 2.2 All of the following:
 - 2.2.1 The Patient is a resident in an institution; and
 - 2.2.2 All residents of the institution with scabies or at risk of carriage are to be treated for scabies concurrently; and
 - 2.2.3 Any of the following:
 - 2.2.3.1 Patient has a severe scabies hyperinfestation (Crusted/ Norwegian scabies); or
 - 2.2.3.2 The patient is physically or mentally unable to comply with the application instructions of topical therapy; or
 - 2.2.3.3 Previous topical therapy has been tried and failed to clear the infestation.

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
---	----------------------------	-------------------------------------

continued...

Note: Ivermectin is no more effective than topical therapy for treatment of standard scabies infestation.

Renewal — (Other parasitic infections) only from an infectious disease specialist, clinical microbiologist or dermatologist.

Approvals valid for 1 month for applications meeting the following criteria:

Any of the following:

- 1 Filaricides; or
- 2 Cutaneous larva migrans (creeping eruption); or
- 3 Strongyloidiasis.

PERMETHRIN

Crm 5%.....	4.95	30 g OP	✓ Lyderm
Lotn 5%.....	3.69	30 ml OP	✓ A-Scabies

PHENOTHRIN

Shampoo 0.5%.....	11.36	200 ml OP	✓ Parasidose
-------------------	-------	-----------	---------------------

Psoriasis and Eczema Preparations

ACITRETIN – Special Authority see [SA1476 below](#) – Retail pharmacy

Cap 10 mg.....	17.86	60	✓ Novatretin
Cap 25 mg.....	41.36	60	✓ Novatretin

► **SA1476** Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 1 year for applications meeting the following criteria:

All of the following:

- 1 Applicant is a vocationally registered dermatologist, vocationally registered general practitioner, or nurse practitioner working in a relevant scope of practice; and
- 2 Applicant has an up to date knowledge of the safety issues around acitretin and is competent to prescribe acitretin; and
- 3 Either:
 - 3.1 Patient is female and has been counselled and understands the risk of teratogenicity if acitretin is used during pregnancy and the applicant has ensured that the possibility of pregnancy has been excluded prior to the commencement of the treatment and that the patient is informed that she must not become pregnant during treatment and for a period of two years after the completion of the treatment; or
 - 3.2 Patient is male.

Renewal from any relevant practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Either:

- 1 Patient is female and has been counselled and understands the risk of teratogenicity if acitretin is used during pregnancy and the applicant has ensured that the possibility of pregnancy has been excluded prior to the commencement of the treatment and that the patient is informed that she must not become pregnant during treatment and for a period of two years after the completion of the treatment; or
- 2 Patient is male.

BETAMETHASONE DIPROPIONATE WITH CALCIPOTRIOL

Gel 500 mcg with calcipotriol 50 mcg per g.....	52.24	60 g OP	✓ Daivobet
Oint 500 mcg with calcipotriol 50 mcg per g.....	19.95	30 g OP	✓ Daivobet

Daivobet to be Sole Supply on 1 January 2019

CALCIPOTRIOL

Oint 50 mcg per g.....	45.00	100 g OP	✓ Daivonex
------------------------	-------	----------	-------------------

COAL TAR

Soln BP – Only in combination.....	32.95	200 ml	✓ Midwest
------------------------------------	-------	--------	------------------

- 1 Up to 10% only in combination with a dermatological base or proprietary Topical Corticosteroid – Plain
- 2 With or without other dermatological galenicals.

DERMATOLOGICALS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
COAL TAR WITH ALLANTOIN, MENTHOL, PHENOL AND SULPHUR				
Soln 5% with sulphur 0.5%, menthol 0.75%, phenol 0.5% and allantoin crm 2.5%.....	6.59 (8.00) 3.43 (4.35)	75 g OP 30 g OP		Egopsoryl TA Egopsoryl TA
COAL TAR WITH SALICYLIC ACID AND SULPHUR				
Soln 12% with salicylic acid 2% and sulphur 4% oint.....	7.95	40 g OP	✓	Coco-Scalp
PINE TAR WITH TROLAMINE LAURILSULFATE AND FLUORESCHEIN – Only on a prescription				
* Soln 2.3% with trolamine laurilsulfate and fluorescein sodium.....	3.86	500 ml	✓	Pinetarsol
SALICYLIC ACID				
Powder – Only in combination.....	18.88	250 g	✓	PSM
1) Only in combination with a dermatological base or proprietary Topical Corticosteroid – Plain or collodion flexible				
2) With or without other dermatological galenicals.				
SULPHUR				
Precipitated – Only in combination.....	6.35	100 g	✓	Midwest
1) Only in combination with a dermatological base or proprietary Topical Corticosteroid – Plain				
2) With or without other dermatological galenicals.				

Scalp Preparations

BETAMETHASONE VALERATE				
* Scalp app 0.1%	7.75	100 ml OP	✓	Beta Scalp
CLOBETASOL PROPIONATE				
* Scalp app 0.05%	6.96	30 ml OP	✓	Dermol
HYDROCORTISONE BUTYRATE				
Scalp lotn 0.1%.....	3.65	100 ml OP	✓	Locoid
KETOCONAZOLE				
Shampoo 2%	2.99	100 ml OP	✓	Sebizole
a) Maximum of 100 ml per prescription				
b) Only on a prescription				

Sunscreens

SUNSCREENS, PROPRIETARY – Subsidy by endorsement				
Only if prescribed for a patient with severe photosensitivity secondary to a defined clinical condition and the prescription is endorsed accordingly.				
Crn.....	3.30 (5.89)	100 g OP		Hamilton Sunscreen
Lotn.....	3.30	100 g OP	✓	Marine Blue Lotion SPF 50+
	5.10	200 g OP	✓	Marine Blue Lotion SPF 50+

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
---	-----	--------------------------	-------------------------------------

Wart Preparations

For salicylic acid preparations refer to PSORIASIS AND ECZEMA PREPARATIONS, [page 69](#)

IMIQUMOD

Crm 5%, 250 mg sachet.....21.72 24 ✓ **Perrigo**

PODOPHYLLOTOXIN

Soln 0.5%33.60 3.5 ml OP ✓ **Condyline**

a) Maximum of 3.5 ml per prescription

b) Only on a prescription

Other Skin Preparations

Antineoplastics

FLUOROURACIL SODIUM

Crm 5%.....7.95 20 g OP ✓ **Efudix**

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

Contraceptives - Non-hormonal

Condoms

CONDOMS

* 49 mm – Up to 144 dev available on a PSO	13.36	144	✓ Shield 49
* 53 mm – Up to 144 dev available on a PSO	1.11	12	✓ Gold Knight
	13.36	144	✓ Shield Blue
* 53 mm (chocolate) – Up to 144 dev available on a PSO.....	1.11	12	✓ Shield Blue
	13.36	144	✓ Gold Knight
* 53 mm (strawberry) – Up to 144 dev available on a PSO	1.11	12	✓ Gold Knight
	13.36	144	✓ Gold Knight
* 56 mm – Up to 144 dev available on a PSO	1.11	12	✓ Gold Knight
	13.36	144	✓ Durex Extra Safe
			✓ Gold Knight
* 56 mm, shaped – Up to 144 dev available on a PSO.....	1.11	12	✓ Durex Confidence
	13.36	144	✓ Durex Confidence
* 60 mm – Up to 144 dev available on a PSO	13.36	144	✓ Shield XL

Contraceptive Devices

INTRA-UTERINE DEVICE

a) Up to 40 dev available on a PSO			
b) Only on a PSO			
* IUD 29.1 mm length x 23.2 mm width	31.60	1	✓ Choice TT380 Short
* IUD 33.6 mm length x 29.9 mm width	31.60	1	✓ Choice TT380 Standard
* IUD 35.5 mm length x 19.6 mm width	31.60	1	✓ Choice Load 375

Contraceptives - Hormonal

Combined Oral Contraceptives

►SA0500 Special Authority for Alternate Subsidy

Initial application from any medical practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 Either:
 - 1.1 Patient is on a Social Welfare benefit; or
 - 1.2 Patient has an income no greater than the benefit; and
- 2 Has tried at least one of the fully funded options and has been unable to tolerate it.

Renewal from any medical practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Either:

- 1 Patient is on a Social Welfare benefit; or
- 2 Patient has an income no greater than the benefit.

Notes: The approval numbers of Special Authorities approved after 1 November 1999 are interchangeable between Mercilon and Marvelon.

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

The additional subsidy will fund Mercilon and Marvelon up to the manufacturer's price for each of these products as identified on the Schedule at 1 November 1999.

Special Authorities approved before 1 November 1999 remain valid until the expiry date and can be renewed providing that women are still either:

- on a Social Welfare benefit; or
- have an income no greater than the benefit.

The approval numbers of Special Authorities approved before 1 November 1999 are interchangeable for products within the combined oral contraceptives and progestogen-only contraceptives groups, except Loette and Microgynon 20 ED

ETHINYLOESTRADIOL WITH DESOGESTREL

* Tab 20 mcg with desogestrel 150 mcg and 7 inert tab.....	6.62 (19.80)	84	Mercilon 28
a) Higher subsidy of \$13.80 per 84 tab with Special Authority see SA0500 on the previous page			
b) Up to 84 tab available on a PSO			
* Tab 30 mcg with desogestrel 150 mcg and 7 inert tab.....	6.62 (19.80)	84	Marvelon 28
a) Higher subsidy of \$13.80 per 84 tab with Special Authority see SA0500 on the previous page			
b) Up to 84 tab available on a PSO			

ETHINYLOESTRADIOL WITH LEVONORGESTREL

* Tab 20 mcg with levonorgestrel 100 mcg and 7 inert tablets – Up to 84 tab available on a PSO	2.18	84	✓ Microgynon 20 ED
* Tab 50 mcg with levonorgestrel 125 mcg and 7 inert tab – Up to 84 tab available on a PSO	9.45	84	✓ Microgynon 50 ED
* Tab 30 mcg with levonorgestrel 150 mcg.....	6.62 (16.50)	63	Microgynon 30
a) Higher subsidy of \$15.00 per 63 tab with Special Authority see SA0500 on the previous page			
b) Up to 63 tab available on a PSO			
* Tab 30 mcg with levonorgestrel 150 mcg and 7 inert tablets – Up to 84 tab available on a PSO	1.77	84	✓ Levlen ED

ETHINYLOESTRADIOL WITH NORETHISTERONE

* Tab 35 mcg with norethisterone 1 mg – Up to 63 tab available on a PSO	6.62	63	✓ Brevinor 1/21
* Tab 35 mcg with norethisterone 1 mg and 7 inert tab – Up to 84 tab available on a PSO	6.62	84	✓ Brevinor 1/28
* Tab 35 mcg with norethisterone 500 mcg – Up to 63 tab available on a PSO	6.62	63	✓ Brevinor 21
* Tab 35 mcg with norethisterone 500 mcg and 7 inert tab – Up to 84 tab available on a PSO	6.62	84	✓ Norimin

Progestogen-only Contraceptives

►SA0500 Special Authority for Alternate Subsidy

Initial application from any medical practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 Either:
 - 1.1 Patient is on a Social Welfare benefit; or

continued...

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

- 1.2 Patient has an income no greater than the benefit; and
- 2 Has tried at least one of the fully funded options and has been unable to tolerate it.

Renewal from any medical practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Either:

- 1 Patient is on a Social Welfare benefit; or
- 2 Patient has an income no greater than the benefit.

Notes: The approval numbers of Special Authorities approved after 1 November 1999 are interchangeable between Mercilon and Marvelon.

The additional subsidy will fund Mercilon and Marvelon up to the manufacturer's price for each of these products as identified on the Schedule at 1 November 1999.

Special Authorities approved before 1 November 1999 remain valid until the expiry date and can be renewed providing that women are still either:

- on a Social Welfare benefit; or
- have an income no greater than the benefit.

The approval numbers of Special Authorities approved before 1 November 1999 are interchangeable for products within the combined oral contraceptives and progestogen-only contraceptives groups, except Loette and Microgynon 20 ED

LEVONORGESTREL

* Tab 30 mcg.....	6.62	84		
	(16.50)			Microlut
a) Higher subsidy of \$13.80 per 84 tab with Special Authority see SA0500 on the previous page				
b) Up to 84 tab available on a PSO				

* Subdermal implant (2 x 75 mg rods) – Up to 3 pack available on a PSO.....	106.92	1	✓	Jadelle
---	--------	---	---	----------------

MEDROXYPROGESTERONE ACETATE

* Inj 150 mg per ml, 1 ml syringe – Up to 5 inj available on a PSO	7.25	1	✓	Depo-Provera
--	------	---	---	---------------------

NORETHISTERONE

* Tab 350 mcg – Up to 84 tab available on a PSO	6.25	84	✓	Noriday 28
---	------	----	---	-------------------

Emergency Contraceptives

LEVONORGESTREL

* Tab 1.5 mg	4.95	1	✓	Postinor-1
a) Maximum of 2 tab per prescription				
b) Up to 5 tab available on a PSO				
c) Note: Direct Provision by a pharmacist permitted under the provisions in Part I of Section A.				

Antiandrogen Oral Contraceptives

Prescribers may code prescriptions "contraceptive" (code "O") when used as indicated for contraception. The period of supply and prescription charge will be as per other contraceptives, as follows:

- \$5.00 prescription charge (patient co-payment) will apply.
- prescription may be written for up to six months supply.

Prescriptions coded in any other way are subject to the non contraceptive prescription charges, and the non-contraceptive period of supply. ie. Prescriptions may be written for up to three months supply.

CYPROTERONE ACETATE WITH ETHINYLOESTRADIOL

* Tab 2 mg with ethinyloestradiol 35 mcg and 7 inert tabs – Up to 168 tab available on a PSO.....	4.67	168	✓	Ginet
---	------	-----	---	--------------

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

Gynaecological Anti-infectives

ACETIC ACID WITH HYDROXYQUINOLINE AND RICINOLEIC ACID

Jelly with glacial acetic acid 0.94%, hydroxyquinoline sulphate 0.025%, glycerol 5% and ricinoleic acid 0.75% with applicator....	8.43 (24.00)	100 g OP	Aci-Jel
---	-----------------	----------	---------

CLOTRIMAZOLE

* Vaginal crm 1% with applicators.....	1.60	35 g OP	✓ <u>Clomazol</u>
* Vaginal crm 2% with applicators.....	2.10	20 g OP	✓ <u>Clomazol</u>

MICONAZOLE NITRATE

* Vaginal crm 2% with applicator	3.88	40 g OP	✓ <u>Micreme</u>
--	------	---------	------------------

NYSTATIN

Vaginal crm 100,000 u per 5 g with applicator(s)	4.45	75 g OP	✓ <u>Nilstat</u>
--	------	---------	------------------

Myometrial and Vaginal Hormone Preparations

ERGOMETRINE MALEATE

Inj 250 mcg per ml, 1 ml ampoule – Up to 5 inj available on a PSO	454.00	5	✓ <u>Ergonovine</u> ^{S29}
Inj 500 mcg per ml, 1 ml ampoule – Up to 5 inj available on a PSO	105.00	5	✓ <u>DBL Ergometrine</u>

(Ergonovine ^{S29} Inj 250 mcg per ml, 1 ml ampoule to be delisted 1 July 2019)

OESTRIOL

* Crm 1 mg per g with applicator.....	6.62	15 g OP	✓ <u>Ovestin</u>
* Pessaries 500 mcg	6.86	15	✓ <u>Ovestin</u>

OXYTOCIN – Up to 5 inj available on a PSO

Inj 5 iu per ml, 1 ml ampoule	3.98	5	✓ <u>Oxytocin BNM</u>
Oxytocin BNM to be Sole Supply on 1 December 2018			
Inj 10 iu per ml, 1 ml ampoule	4.98 5.03	5	✓ <u>Oxytocin BNM</u> ✓ <u>Oxytocin Apotex</u>

Oxytocin BNM to be Sole Supply on 1 December 2018

(Oxytocin Apotex Inj 10 iu per ml, 1 ml ampoule to be delisted 1 December 2018)

OXYTOCIN WITH ERGOMETRINE MALEATE – Up to 5 inj available on a PSO

Inj 5 iu with ergometrine maleate 500 mcg per ml, 1 ml	15.00	5	✓ <u>Syntometrine</u>
--	-------	---	-----------------------

Pregnancy Tests - hCG Urine

PREGNANCY TESTS - HCG URINE

a) Up to 200 test available on a PSO			
b) Only on a PSO			
Cassette	12.00 (17.60)	40 test OP	✓ <u>Smith BioMed Rapid Pregnancy Test</u> EasyCheck

Smith BioMed Rapid Pregnancy Test to be Sole Supply on 1 December 2018

(EasyCheck Cassette to be delisted 1 December 2018)

Urinary Agents

For urinary tract Infections refer to INFECTIONS, Antibacterials, [page 108](#)

5-Alpha Reductase Inhibitors

FINASTERIDE – Special Authority see [SA0928 below](#) – Retail pharmacy

* Tab 5 mg	4.81	100	✓ Ricit
------------------	------	-----	----------------

➔ [SA0928](#) **Special Authority for Subsidy**

Initial application from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- 1 Patient has symptomatic benign prostatic hyperplasia; and
- 2 Either:
 - 2.1 The patient is intolerant of non-selective alpha blockers or these are contraindicated; or
 - 2.2 Symptoms are not adequately controlled with non-selective alpha blockers.

Note: Patients with enlarged prostates are the appropriate candidates for therapy with finasteride.

Alpha-1A Adrenoreceptor Blockers

TAMSULOSIN HYDROCHLORIDE – Special Authority see [SA1032 below](#) – Retail pharmacy

* Cap 400 mcg	11.25	100	✓ Tamsulosin-Rex
---------------------	-------	-----	-------------------------

➔ [SA1032](#) **Special Authority for Subsidy**

Initial application from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- 1 Patient has symptomatic benign prostatic hyperplasia; and
- 2 The patient is intolerant of non-selective alpha blockers or these are contraindicated.

Other Urinary Agents

OXYBUTYNIN

* Tab 5 mg	1.77	100	✓ Ditropan <small>\$29</small>
	8.85	500	✓ Apo-Oxybutynin <small>\$29</small>

* Oral liq 5 mg per 5 ml	60.40	473 ml	✓ Apo-Oxybutynin
--------------------------------	-------	--------	-------------------------

(Ditropan \$29 Tab 5 mg to be delisted 1 February 2019)

POTASSIUM CITRATE

Oral liq 3 mmol per ml – Special Authority see [SA1083 below](#) –

Retail pharmacy.....	31.80	200 ml OP	✓ Biomed
----------------------	-------	-----------	-----------------

➔ [SA1083](#) **Special Authority for Subsidy**

Initial application from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 The patient has recurrent calcium oxalate urolithiasis; and
- 2 The patient has had more than two renal calculi in the two years prior to the application.

Renewal from any relevant practitioner. Approvals valid for 2 years where the treatment remains appropriate and the patient is benefitting from the treatment.

SODIUM CITRO-TARTRATE

* Grans eff 4 g sachets	2.34	28	✓ Ural
-------------------------------	------	----	---------------

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
SOLIFENACIN SUCCINATE				
Tab 5 mg	3.00	30	✓	Solifenacin Mylan
Tablet 5 mg – Special Authority see SA0998 below – Retail pharmacy.....	37.50	30	✓	Vesicare
Tab 10 mg	5.50	30	✓	Solifenacin Mylan
Tablet 10 mg – Special Authority see SA0998 below – Retail pharmacy.....	37.50	30	✓	Vesicare
»SA0998 Special Authority for Subsidy				
Initial application from any relevant practitioner. Approvals valid without further renewal unless notified where the patient has overactive bladder and a documented intolerance of, or is non-responsive to oxybutynin.				
TOLTERODINE – Special Authority see SA1272 below – Retail pharmacy				
Tab 1 mg	14.56	56	✓	Arrow-Tolterodine
Tab 2 mg	14.56	56	✓	Arrow-Tolterodine

»SA1272 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid without further renewal unless notified where patient has overactive bladder and a documented intolerance of, or is non-responsive to oxybutynin.

Detection of Substances in Urine

ORTHO-TOLIDINE				
* Compound diagnostic sticks.....	7.50 (8.25)	50 test OP		Hemastix
TETRABROMOPHENOL				
* Blue diagnostic strips.....	7.02 (13.92)	100 test OP		Albustix

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

Calcium Homeostasis

CALCITONIN

* Inj 100 iu per ml, 1 ml ampoule 121.00 5 ✓ **Miacalcic**

CINACALCET – Special Authority see [SA1618 below](#) – Retail pharmacy

Tab 30 mg – Wastage claimable 210.30 28 ✓ **Sensipar**

►SA1618 Special Authority for Subsidy

Initial application only from a nephrologist or endocrinologist. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 All of the following:
 - 1.1 The patient has been diagnosed with a parathyroid carcinoma (see Note); and
 - 1.2 The patient has persistent hypercalcaemia (serum calcium greater than or equal to 3 mmol/L) despite previous first-line treatments including sodium thiosulfate (where appropriate) and bisphosphonates; and
 - 1.3 The patient is symptomatic; or
- 2 All of the following:
 - 2.1 The patient has been diagnosed with calciphylaxis (calcific uraemic arteriopathy); and
 - 2.2 The patient has symptomatic (e.g. painful skin ulcers) hypercalcaemia (serum calcium greater than or equal to 3 mmol/L); and
 - 2.3 The patient's condition has not responded to previous first-line treatments including bisphosphonates and sodium thiosulfate.

Renewal only from a nephrologist or endocrinologist. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- 1 The patient's serum calcium level has fallen to < 3mmol/L; and
- 2 The patient has experienced clinically significant symptom improvement.

Note: This does not include parathyroid adenomas unless these have become malignant.

ZOLEDRONIC ACID

Inj 4 mg per 5 ml, vial – Special Authority see [SA1687 below](#) –

Retail pharmacy.....	84.50	1	✓ Zoledronic acid
			Mylan
	550.00		✓ Zometa

►SA1687 Special Authority for Subsidy

Initial application — (bone metastases) only from an oncologist, haematologist or palliative care specialist. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Any of the following:

- 1 Patient has hypercalcaemia of malignancy; or
- 2 Both:
 - 2.1 Patient has bone metastases or involvement; and
 - 2.2 Patient has severe bone pain resistant to standard first-line treatments; or
- 3 Both:
 - 3.1 Patient has bone metastases or involvement; and
 - 3.2 Patient is at risk of skeletal-related events pathological fracture, spinal cord compression, radiation to bone or surgery to bone.

Initial application — (early breast cancer) only from an oncologist or medical practitioner on the recommendation of a oncologist. Approvals valid for 2 years for applications meeting the following criteria:

continued...

HORMONE PREPARATIONS - SYSTEMIC EXCLUDING CONTRACEPTIVE HORMONES

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

All of the following:

- 1 Treatment to be used as adjuvant therapy for early breast cancer; and
- 2 Patient has been amenorrhoeic for 12 months or greater, either naturally or induced, with endocrine levels consistent with a postmenopausal state; and
- 3 Treatment to be administered at a minimum interval of 6-monthly for a maximum of 2 years.

Corticosteroids and Related Agents for Systemic Use

BETAMETHASONE SODIUM PHOSPHATE WITH BETAMETHASONE ACETATE

* Inj 3.9 mg with betamethasone acetate 3 mg per ml, 1 ml.....	19.20 (36.96)	5	
			Celestone Chronodose

DEXAMETHASONE

* Tab 0.5 mg – Retail pharmacy-Specialist.....	0.99	30	✓ <u>Dexamethsone</u>
Up to 60 tab available on a PSO			
* Tab 4 mg – Retail pharmacy-Specialist.....	1.90	30	✓ <u>Dexamethsone</u>
Up to 30 tab available on a PSO			
Oral liq 1 mg per ml – Retail pharmacy-Specialist.....	45.00	25 ml OP	✓ <u>Biomed</u>
Oral liq prescriptions:			
1) Must be written by a Paediatrician or Paediatric Cardiologist; or			
2) On the recommendation of a Paediatrician or Paediatric Cardiologist.			

DEXAMETHASONE PHOSPHATE

Dexamethasone phosphate injection will not be funded for oral use.

* Inj 4 mg per ml, 1 ml ampoule – Up to 5 inj available on a PSO	14.19	10	✓ <u>Max Health</u>
* Inj 4 mg per ml, 2 ml ampoule – Up to 5 inj available on a PSO	25.18	10	✓ <u>Max Health</u>

FLUDROCORTISONE ACETATE

* Tab 100 mcg.....	14.32	100	✓ <u>Florinef</u>
--------------------	-------	-----	-------------------

HYDROCORTISONE

* Tab 5 mg	8.10	100	✓ <u>Douglas</u>
* Tab 20 mg	20.32	100	✓ <u>Douglas</u>
* Inj 100 mg vial	5.30	1	✓ <u>Solu-Cortef</u>
a) Up to 5 inj available on a PSO			
b) Only on a PSO			

METHYLPREDNISOLONE – Retail pharmacy-Specialist

* Tab 4 mg	112.00	100	✓ <u>Medrol</u>
Medrol to be Sole Supply on 1 January 2019			
* Tab 100 mg	194.00	20	✓ <u>Medrol</u>
Medrol to be Sole Supply on 1 January 2019			

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

HORMONE PREPARATIONS - SYSTEMIC EXCLUDING CONTRACEPTIVE HORMONES

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
METHYLPREDNISOLONE (AS SODIUM SUCCINATE) – Retail pharmacy-Specialist				
Inj 40 mg vial	18.90	1	✓	Solu-Medrol-Act-O-Vial
Solu-Medrol-Act-O-Vial to be Sole Supply on 1 January 2019				
Inj 125 mg vial	28.90	1	✓	Solu-Medrol-Act-O-Vial
Solu-Medrol-Act-O-Vial to be Sole Supply on 1 January 2019				
Inj 500 mg vial	22.78	1	✓	Solu-Medrol-Act-O-Vial
Solu-Medrol-Act-O-Vial to be Sole Supply on 1 January 2019				
Inj 1 g vial	27.83	1	✓	Solu-Medrol
Solu-Medrol to be Sole Supply on 1 January 2019				
METHYLPREDNISOLONE ACETATE				
Inj 40 mg per ml, 1 ml vial.....	44.40	5	✓	Depo-Medrol
METHYLPREDNISOLONE ACETATE WITH LIDOCAINE [LIGNOCAINE]				
Inj 40 mg per ml with lidocaine [lignocaine] 1 ml vial.....	9.25	1	✓	Depo-Medrol with Lidocaine
PREDNISOLONE				
* Oral liq 5 mg per ml – Up to 30 ml available on a PSO	6.00	30 ml OP	✓	Redipred
Restricted to children under 12 years of age.				
PREDNISONE				
* Tab 1 mg	10.68	500	✓	Apo-Prednisone
* Tab 2.5 mg	12.09	500	✓	Apo-Prednisone
* Tab 5 mg – Up to 30 tab available on a PSO	11.09	500	✓	Apo-Prednisone
* Tab 20 mg	29.03	500	✓	Apo-Prednisone
TETRACOSACTRIN				
* Inj 250 mcg per ml, 1 ml ampoule	75.00	1	✓	Synacthen
* Inj 1 mg per ml, 1 ml ampoule	690.00	1	✓	Synacthen Depot
TRIAMCINOLONE ACETONIDE				
Inj 10 mg per ml, 1 ml ampoule	20.80	5	✓	Kenacort-A 10
Inj 40 mg per ml, 1 ml ampoule	51.10	5	✓	Kenacort-A 40

Sex Hormones Non Contraceptive

Androgen Agonists and Antagonists

CYPROTERONE ACETATE – Retail pharmacy-Specialist				
Tab 50 mg	13.17	50	✓	Siterone
	15.87		✓	Procur
Tab 100 mg	26.75	50	✓	Siterone
	30.40		✓	Procur
TESTOSTERONE				
Patch 5 mg per day	80.00	30	✓	Androderm
TESTOSTERONE CIPIONATE – Retail pharmacy-Specialist				
Inj 100 mg per ml, 10 ml vial.....	76.50	1	✓	Depo-Testosterone
TESTOSTERONE ESTERS – Retail pharmacy-Specialist				
Inj 250 mg per ml, 1 ml.....	12.98	1	✓	Sustanon Ampoules

HORMONE PREPARATIONS - SYSTEMIC EXCLUDING CONTRACEPTIVE HORMONES

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
TESTOSTERONE UNDECANOATE – Retail pharmacy-Specialist				
Cap 40 mg.....	21.00	60	✓	Andriol Testocaps
Andriol Testocaps to be Sole Supply on 1 December 2018				
Inj 250 mg per ml, 4 ml vial.....	86.00	1	✓	Reandron 1000

Hormone Replacement Therapy - Systemic

Prescribing Guideline

HRT should be taken at the lowest dose for the shortest period of time necessary to control symptoms. Patients should be reviewed 6 monthly in line with the updated NZGG “Evidence-based Best Practice Guideline on Hormone Replacement Therapy March 2004”.

Oestrogens

OESTRADIOL – See prescribing guideline [above](#)

* Tab 1 mg.....	4.12 (11.10)	28 OP		Estrofem
* Tab 2 mg.....	4.12 (11.10)	28 OP		Estrofem
* Patch 25 mcg per day.....	6.12	8	✓	<u>Estradot</u>
a) No more than 2 patch per week				
b) Only on a prescription				
* Patch 50 mcg per day.....	7.04	8	✓	<u>Estradot 50 mcg</u>
a) No more than 2 patch per week				
b) Only on a prescription				
* Patch 75 mcg per day.....	7.91	8	✓	<u>Estradot</u>
a) No more than 2 patch per week				
b) Only on a prescription				
* Patch 100 mcg per day.....	7.91	8	✓	<u>Estradot</u>
a) No more than 2 patch per week				
b) Only on a prescription				

OESTRADIOL VALERATE – See prescribing guideline [above](#)

* Tab 1 mg.....	12.36	84	✓	<u>Progynova</u>
* Tab 2 mg.....	12.36	84	✓	<u>Progynova</u>

OESTROGENS – See prescribing guideline [above](#)

* Conjugated, equine tab 300 mcg.....	3.01 (13.50)	28		Premarin
* Conjugated, equine tab 625 mcg.....	4.12 (13.50)	28		Premarin

Progestogens

MEDROXYPROGESTERONE ACETATE – See prescribing guideline [above](#)

* Tab 2.5 mg.....	3.75	30	✓	<u>Provera</u>
* Tab 5 mg.....	14.00	100	✓	<u>Provera</u>
* Tab 10 mg.....	7.15	30	✓	<u>Provera</u>

▲Three months supply may be dispensed at one time if endorsed “certified exemption” by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

HORMONE PREPARATIONS - SYSTEMIC EXCLUDING CONTRACEPTIVE HORMONES

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
Progestogen and Oestrogen Combined Preparations				
OESTRADIOL WITH NORETHISTERONE – See prescribing guideline on the previous page				
* Tab 1 mg with 0.5 mg norethisterone acetate	5.40 (18.10)	28 OP		Kliovance
* Tab 2 mg with 1 mg norethisterone acetate	5.40 (18.10)	28 OP		Kliogest
* Tab 2 mg with 1 mg norethisterone acetate (10), and 2 mg oestradiol tab (12) and 1 mg oestradiol tab (6).....	5.40 (18.10)	28 OP		Trisequens
Other Oestrogen Preparations				
ETHINYLOESTRADIOL				
* Tab 10 mcg.....	17.60	100	✓	NZ Medical and Scientific
OESTRIOL				
* Tab 2 mg	7.00	30	✓	Ovestin
Other Progestogen Preparations				
LEVONORGESTREL				
* Intra-uterine system 20 mcg per day – Special Authority see SA1608 below – Retail pharmacy	269.50	1	✓	Mirena
» SA1608 Special Authority for Subsidy				
Initial application — (No previous use) only from a relevant specialist or general practitioner. Approvals valid for 6 months for applications meeting the following criteria:				
All of the following:				
1 The patient has a clinical diagnosis of heavy menstrual bleeding; and				
2 The patient has failed to respond to or is unable to tolerate other appropriate pharmaceutical therapies as per the Heavy Menstrual Bleeding Guidelines; and				
3 Either:				
3.1 serum ferritin level < 16 mcg/l (within the last 12 months); or				
3.2 haemoglobin level < 120 g/l.				
Note: Applications are not to be made for use in patients as contraception except where they meet the above criteria.				
Renewal only from a relevant specialist or general practitioner. Approvals valid for 6 months for applications meeting the following criteria:				
Both:				
1 Either:				
1.1 Patient demonstrated clinical improvement of heavy menstrual bleeding; or				
1.2 Previous insertion was removed or expelled within 3 months of insertion; and				
2 Applicant to state date of the previous insertion.				
MEDROXYPROGESTERONE ACETATE				
* Tab 100 mg – Retail pharmacy-Specialist.....	101.00	100	✓	Provera HD
NORETHISTERONE				
* Tab 5 mg – Up to 30 tab available on a PSO	18.29	100	✓	Primolut N
PROGESTERONE				
Cap 100 mg – Special Authority see SA1609 on the next page				
– Retail pharmacy.....	16.50	30	✓	Utrogestan

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

►SA1609 Special Authority for Subsidy

Initial application only from an obstetrician or gynaecologist. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 For the prevention of pre-term labour*; and
- 2 Either:
 - 2.1 The patient has a short cervix on ultrasound (defined as < 25 mm at 16 to 28 weeks); or
 - 2.2 The patient has a history of pre-term birth at less than 28 weeks.

Renewal only from an obstetrician or gynaecologist. Approvals valid for 12 months for applications meeting the following criteria: All of the following:

- 1 For the prevention of pre-term labour*; and
- 2 Treatment is required for second or subsequent pregnancy; and
- 3 Either:
 - 3.1 The patient has a short cervix on ultrasound (defined as < 25 mm at 16 to 28 weeks); or
 - 3.2 The patient has a history of pre-term birth at less than 28 weeks.

Note: Indications marked with * are unapproved indications.

Thyroid and Antithyroid Agents

CARBIMAZOLE

* Tab 5 mg	10.80	100	✓ AFT Carbimazole ^{§29}
			✓ Neo-Mercazole

LEVOTHYROXINE

* Tab 25 mcg.....	3.89	90	✓ Synthroid
* Tab 50 mcg.....	1.71	28	✓ Mercury Pharma
	4.05	90	✓ Synthroid
	64.28	1,000	✓ Eltroxin
* Tab 100 mcg.....	1.78	28	✓ Mercury Pharma
	4.21	90	✓ Synthroid
	66.78	1,000	✓ Eltroxin

PROPYLTHIOURACIL – Special Authority see SA1199 below – Retail pharmacy

Propylthiouracil is not recommended for patients under the age of 18 years unless the patient is pregnant and other treatments are contraindicated.

Tab 50 mg	35.00	100	✓ PTU ^{§29}
-----------------	-------	-----	----------------------

►SA1199 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 The patient has hyperthyroidism; and
- 2 The patient is intolerant of carbimazole or carbimazole is contraindicated.

Renewal from any relevant practitioner. Approvals valid for 2 years where the treatment remains appropriate and the patient is benefitting from the treatment.

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

Trophic Hormones

Growth Hormones

SOMATROPIN (OMNITROPE) – Special Authority see [SA1629 below](#) – Retail pharmacy

* Inj 5 mg cartridge.....	34.88	1	✓	<u>Omnitrope</u>
* Inj 10 mg cartridge.....	69.75	1	✓	<u>Omnitrope</u>
* Inj 15 mg cartridge.....	104.63	1	✓	<u>Omnitrope</u>

► [SA1629](#) Special Authority for Subsidy

Initial application — (growth hormone deficiency in children) only from a paediatric endocrinologist or endocrinologist.

Approvals valid for 9 months for applications meeting the following criteria:

Either:

- 1 Growth hormone deficiency causing symptomatic hypoglycaemia, or with other significant growth hormone deficient sequelae (e.g. cardiomyopathy, hepatic dysfunction) and diagnosed with GH < 5 mcg/l on at least two random blood samples in the first 2 weeks of life, or from samples during established hypoglycaemia (whole blood glucose < 2 mmol/l using a laboratory device); or
- 2 All of the following:
 - 2.1 Height velocity < 25th percentile for age adjusted for bone age/pubertal status if appropriate over 6 or 12 months using the standards of Tanner and Davies (1985); and
 - 2.2 A current bone age is < 14 years (female patients) or < 16 years (male patients); and
 - 2.3 Peak growth hormone value of < 5.0 mcg per litre in response to two different growth hormone stimulation tests. In children who are 5 years or older, GH testing with sex steroid priming is required; and
 - 2.4 If the patient has been treated for a malignancy, they should be disease free for at least one year based upon follow-up laboratory and radiological imaging appropriate for the malignancy, unless there are strong medical reasons why this is either not necessary or appropriate; and
 - 2.5 Appropriate imaging of the pituitary gland has been obtained.

Renewal — (growth hormone deficiency in children) only from a paediatric endocrinologist or endocrinologist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 A current bone age is 14 years or under (female patients) or 16 years or under (male patients); and
- 2 Height velocity is greater than or equal to 25th percentile for age (adjusted for bone age/pubertal status if appropriate) while on growth hormone treatment, as calculated over six months using the standards of Tanner and Davis (1985); and
- 3 Height velocity is greater than or equal to 2.0 cm per year, as calculated over 6 months; and
- 4 No serious adverse effect that the patients specialist considers is likely to be attributable to growth hormone treatment has occurred; and
- 5 No malignancy has developed since starting growth hormone.

Initial application — (Turner syndrome) only from a paediatric endocrinologist or endocrinologist. Approvals valid for 9 months for applications meeting the following criteria:

All of the following:

- 1 The patient has a post-natal genotype confirming Turner Syndrome; and
- 2 Height velocity is < 25th percentile over 6-12 months using the standards of Tanner and Davies (1985); and
- 3 A current bone age is < 14 years.

Renewal — (Turner syndrome) only from a paediatric endocrinologist or endocrinologist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Height velocity is greater than or equal to 50th percentile for age (while on growth hormone calculated over 6 to 12 months using the Rank's Turner Syndrome growth velocity charts); and
- 2 Height velocity is greater than or equal to 2 cm per year, calculated over six months; and

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

- 3 A current bone age is 14 years or under ; and
- 4 No serious adverse effect that the specialist considers is likely to be attributable to growth hormone treatment has occurred; and
- 5 No malignancy has developed since starting growth hormone.

Initial application — (short stature without growth hormone deficiency) only from a paediatric endocrinologist or endocrinologist. Approvals valid for 9 months for applications meeting the following criteria:

All of the following:

- 1 The patient's height is more than 3 standard deviations below the mean for age or for bone age if there is marked growth acceleration or delay; and
- 2 Height velocity is < 25th percentile for age (adjusted for bone age/pubertal status if appropriate), as calculated over 6 to 12 months using the standards of Tanner and Davies(1985); and
- 3 A current bone age is < 14 years or under (female patients) or < 16 years (male patients); and
- 4 The patient does not have severe chronic disease (including malignancy or recognized severe skeletal dysplasia) and is not receiving medications known to impair height velocity.

Renewal — (short stature without growth hormone deficiency) only from a paediatric endocrinologist or endocrinologist.

Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Height velocity is greater than or equal to 50th percentile (adjusted for bone age/pubertal status if appropriate) as calculated over 6 to 12 months using the standards of Tanner and Davies (1985); and
- 2 Height velocity is greater than or equal to 2 cm per year as calculated over six months; and
- 3 A current bone age is 14 years or under (female patients) or 16 years or under (male patients); and
- 4 No serious adverse effect that the patient's specialist considers is likely to be attributable to growth hormone treatment has occurred.

Initial application — (short stature due to chronic renal insufficiency) only from a paediatric endocrinologist, endocrinologist or renal physician on the recommendation of a paediatric endocrinologist or endocrinologist. Approvals valid for 9 months for applications meeting the following criteria:

All of the following:

- 1 The patient's height is more than 2 standard deviations below the mean; and
- 2 Height velocity is < 25th percentile (adjusted for bone age/pubertal status if appropriate) as calculated over 6 to 12 months using the standards of Tanner and Davies (1985); and
- 3 A current bone age is to 14 years or under (female patients) or to 16 years or under (male patients); and
- 4 The patient is metabolically stable, has no evidence of metabolic bone disease and absence of any other severe chronic disease; and
- 5 The patient is under the supervision of a specialist with expertise in renal medicine; and
- 6 Either:
 - 6.1 The patient has a GFR less than or equal to 30 ml/min/1.73m² as measured by the Schwartz method (Height(cm)/plasma creatinine (umol/l) × 40 = corrected GFR (ml/min/1.73m² in a child who may or may not be receiving dialysis; or
 - 6.2 The patient has received a renal transplant and has received < 5mg/ m²/day of prednisone or equivalent for at least 6 months..

Renewal — (short stature due to chronic renal insufficiency) only from a paediatric endocrinologist, endocrinologist or renal physician on the recommendation of a paediatric endocrinologist or endocrinologist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Height velocity is greater than or equal to 50th percentile (adjusted for bone age/pubertal status if appropriate) as calculated over 6 to 12 months using the standards of Tanner and Davies (1985); and
- 2 Height velocity is greater than or equal to 2 cm per year as calculated over six months; and

continued...

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
--	---	------------------------------	-------------------------------------

continued...

- 3 A current bone age is 14 years or under (female patients) or 16 years or under (male patients); and
- 4 No serious adverse effect that the patients specialist considers is likely to be attributable to growth hormone has occurred; and
- 5 No malignancy has developed after growth hormone therapy was commenced; and
- 6 The patient has not experienced significant biochemical or metabolic deterioration confirmed by diagnostic results; and
- 7 The patient has not received renal transplantation since starting growth hormone treatment; and
- 8 If the patient requires transplantation, growth hormone prescription should cease before transplantation and a new application should be made after transplantation based on the above criteria.

Initial application — (Prader-Willi syndrome) only from a paediatric endocrinologist or endocrinologist. Approvals valid for 9 months for applications meeting the following criteria:

All of the following:

- 1 The patient has a diagnosis of Prader-Willi syndrome that has been confirmed by genetic testing or clinical scoring criteria; and
- 2 The patient is aged six months or older; and
- 3 A current bone age is < 14 years (female patients) or < 16 years (male patients); and
- 4 Sleep studies or overnight oximetry have been performed and there is no obstructive sleep disorder requiring treatment, or if an obstructive sleep disorder is found, it has been adequately treated under the care of a paediatric respiratory physician and/or ENT surgeon; and
- 5 Either:
 - 5.1 Both:
 - 5.1.1 The patient is aged two years or older; and
 - 5.1.2 There is no evidence of type II diabetes or uncontrolled obesity defined by BMI that has increased by greater than or equal to 0.5 standard deviations in the preceding 12 months; or
 - 5.2 The patient is aged between six months and two years and a thorough upper airway assessment is planned to be undertaken prior to treatment commencement and at six to 12 weeks following treatment initiation.

Renewal — (Prader-Willi syndrome) only from a paediatric endocrinologist or endocrinologist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Height velocity is greater than or equal to 50th percentile (adjusted for bone age/pubertal status if appropriate) as calculated over 6 to 12 months using the standards of Tanner and Davies (1985); and
- 2 Height velocity is greater than or equal to 2 cm per year as calculated over six months; and
- 3 A current bone age is 14 years or under (female patients) or 16 years or under (male patients); and
- 4 No serious adverse effect that the patient's specialist considers is likely to be attributable to growth hormone treatment has occurred; and
- 5 No malignancy has developed after growth hormone therapy was commenced; and
- 6 The patient has not developed type II diabetes or uncontrolled obesity as defined by BMI that has increased by greater than or equal to 0.5 standard deviations in the preceding 12 months.

Initial application — (adults and adolescents) only from a paediatric endocrinologist or endocrinologist. Approvals valid for 9 months for applications meeting the following criteria:

All of the following:

- 1 The patient has a medical condition that is known to cause growth hormone deficiency (e.g. surgical removal of the pituitary for treatment of a pituitary tumour); and
- 2 The patient has undergone appropriate treatment of other hormonal deficiencies and psychological illnesses; and
- 3 The patient has severe growth hormone deficiency (see notes); and
- 4 The patient's serum IGF-I is more than 1 standard deviation below the mean for age and sex; and
- 5 The patient has poor quality of life, as defined by a score of 16 or more using the disease-specific quality of life questionnaire for adult growth hormone deficiency (QoL-AGHDA®).

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

Notes: For the purposes of adults and adolescents, severe growth hormone deficiency is defined as a peak serum growth hormone level of less than or equal to 3 mcg per litre during an adequately performed insulin tolerance test (ITT) or glucagon stimulation test.

Patients with one or more additional anterior pituitary hormone deficiencies and a known structural pituitary lesion only require one test. Patients with isolated growth hormone deficiency require two growth hormone stimulation tests, of which, one should be ITT unless otherwise contraindicated. Where an additional test is required, an arginine provocation test can be used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre.

The dose of somatropin should be started at 0.2 mg daily and be titrated by 0.1 mg monthly until the serum IGF-I is within 1 standard deviation of the mean normal value for age and sex; and

Dose of somatropin not to exceed 0.7 mg per day for male patients, or 1 mg per day for female patients.

At the commencement of treatment for hypopituitarism, patients must be monitored for any required adjustment in replacement doses of corticosteroid and levothyroxine.

Renewal — (adults and adolescents) only from a paediatric endocrinologist or endocrinologist. Approvals valid for 12 months for applications meeting the following criteria:

Either:

- 1 All of the following:
 - 1.1 The patient has been treated with somatropin for < 12 months; and
 - 1.2 There has been an improvement in Quality of Life defined as a reduction of at least 8 points on the Quality of Life Assessment of Growth Hormone Deficiency in Adults (QoL-AGHDA®) score from baseline; and
 - 1.3 Serum IGF-I levels have been increased within $\pm 1SD$ of the mean of the normal range for age and sex; and
 - 1.4 The dose of somatropin has not exceeded 0.7 mg per day for male patients, or 1 mg per day for female patients; or
- 2 All of the following:
 - 2.1 The patient has been treated with somatropin for more than 12 months; and
 - 2.2 The patient has not had a deterioration in Quality of Life defined as a 6 point or greater increase from their lowest QoL-AGHDA® score on treatment (other than due to obvious external factors such as external stressors); and
 - 2.3 Serum IGF-I levels have continued to be maintained within $\pm 1SD$ of the mean of the normal range for age and sex (other than for obvious external factors); and
 - 2.4 The dose of somatropin has not exceeded 0.7 mg per day for male patients or 1 mg per day for female patients.

GnRH Analogues

GOSERELIN

Implant 3.6 mg, syringe	66.48	1	✓ Zoladex
Implant 10.8 mg, syringe	177.50	1	✓ Zoladex

LEUPRORELIN

Additional subsidy by endorsement where the patient is a child or adolescent and is unable to tolerate administration of goserelin and the prescription is endorsed accordingly.

Inj 3.75 mg prefilled dual chamber syringe – Higher subsidy of

\$221.60 per 1 inj with Endorsement	66.48	1	
	(221.60)		Lucrin Depot 1-month

Inj 11.25 mg prefilled dual chamber syringe – Higher subsidy

of \$591.68 per 1 inj with Endorsement	177.50	1	
	(591.68)		Lucrin Depot 3-month

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

Vasopressin Agonists

DESMOPRESSIN ACETATE

Tab 100 mcg – Special Authority see SA1401 below – Retail pharmacy.....	25.00	30	✓	<u>Minirin</u>
Tab 200 mcg – Special Authority see SA1401 below – Retail pharmacy.....	54.45	30	✓	<u>Minirin</u>
▲ Nasal drops 100 mcg per ml – Retail pharmacy-Specialist.....	39.03	2.5 ml OP	✓	<u>Minirin</u>
▲ Nasal spray 10 mcg per dose – Retail pharmacy-Specialist.....	23.95	6 ml OP	✓	<u>Desmopressin-PH&T</u>
Inj 4 mcg per ml, 1 ml – Special Authority see SA1401 below – Retail pharmacy.....	67.18	10	✓	<u>Minirin</u>

► [SA1401](#) Special Authority for Subsidy

Initial application — (Desmopressin tablets for Nocturnal enuresis) from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient has primary nocturnal enuresis; and
- 2 The nasal forms of desmopressin are contraindicated; and
- 3 An enuresis alarm is contraindicated.

Initial application — (Desmopressin tablets for Diabetes insipidus) from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 The patient has cranial diabetes insipidus; and
- 2 The nasal forms of desmopressin are contraindicated.

Renewal — (Desmopressin tablets) from any relevant practitioner. Approvals valid for 12 months where the treatment remains appropriate and the patient is benefiting from the treatment.

Initial application — (Desmopressin injection) only from a relevant specialist. Approvals valid for 2 years where the patient cannot use desmopressin nasal spray or nasal drops.

Renewal — (Desmopressin injection) only from a relevant specialist. Approvals valid for 2 years where the treatment remains appropriate and the patient is benefiting from treatment.

Other Endocrine Agents

CABERGOLINE

Tab 0.5 mg – Maximum of 2 tab per prescription; can be waived by Special Authority see SA1370 below	3.75	2	✓	<u>Dostinex</u>
	15.20	8	✓	<u>Dostinex</u>

► [SA1370](#) Special Authority for Waiver of Rule

Initial application from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Either:

- 1 pathological hyperprolactinemia; or
- 2 acromegaly*.

Renewal — (for patients who have previously been funded under Special Authority form SA1031) from any relevant practitioner. Approvals valid without further renewal unless notified where the patient has previously held a valid Special Authority which has expired and the treatment remains appropriate and the patient is benefiting from treatment.

Note: Indication marked with * is an unapproved indication.

HORMONE PREPARATIONS - SYSTEMIC EXCLUDING CONTRACEPTIVE HORMONES

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
CLOMIFENE CITRATE				
Tab 50 mg	29.84	10	✓	Mylan Clomiphene ^{S29} Serophene
DANAZOL				
Cap 100 mg	68.33	100	✓	Azol
Cap 200 mg	97.83	100	✓	Azol
METYRAPONE				
Cap 250 mg – Retail pharmacy-Specialist	520.00	50	✓	Metopirone

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

Anthelmintics

ALBENDAZOLE – Special Authority see [SA1318 below](#) – Retail pharmacy

Tab 400 mg	469.20	60	✓	Eskazole <small>\$29</small>
------------------	--------	----	---	-------------------------------------

► [SA1318](#) **Special Authority for Subsidy**

Initial application only from an infectious disease specialist or clinical microbiologist. Approvals valid for 6 months where the patient has hydatids.

Renewal only from an infectious disease specialist or clinical microbiologist. Approvals valid for 6 months where the treatment remains appropriate and the patient is benefitting from the treatment.

MEBENDAZOLE – Only on a prescription

Tab 100 mg	24.19	24	✓	De-Worm
Oral liq 100 mg per 5 ml	2.18	15 ml		Vermox
	(7.17)			

PRAZIQUANTEL

Tab 600 mg	68.00	8	✓	Biltricide
------------------	-------	---	---	-------------------

Antibacterials

a) For topical antibacterials, refer to DERMATOLOGICALS, [page 62](#)

b) For anti-infective eye preparations, refer to SENSORY ORGANS, [page 208](#)

Cephalosporins and Cephamycins

CEFACTOR MONOHYDRATE

Cap 250 mg	24.70	100	✓	Ranbaxy-Cefaclor
Grans for oral liq 125 mg per 5 ml – Wastage claimable	3.53	100 ml	✓	Ranbaxy-Cefaclor

CEFALEXIN

Cap 250 mg	3.50	20	✓	Cephalexin ABM
Cap 500 mg	3.95	20	✓	Cephalexin ABM
Grans for oral liq 25 mg per ml – Wastage claimable	8.75	100 ml	✓	Cefalexin Sandoz
Note: Cefalexin grans for oral liq will not be funded in amounts more than 14 days treatment per dispensing.				
Grans for oral liq 50 mg per ml – Wastage claimable	11.75	100 ml	✓	Cefalexin Sandoz
Note: Cefalexin grans for oral liq will not be funded in amounts more than 14 days treatment per dispensing.				

CEFAZOLIN – Subsidy by endorsement

Only if prescribed for dialysis or cellulitis in accordance with a DHB approved protocol and the prescription is endorsed accordingly.

Inj 500 mg vial	3.39	5	✓	AFT
Inj 1 g vial	3.29	5	✓	AFT

CEFTRIAXONE – Subsidy by endorsement

a) Up to 5 inj available on a PSO

b) Subsidised only if prescribed for a dialysis or cystic fibrosis patient, or the treatment of gonorrhoea, or the treatment of pelvic inflammatory disease, or the treatment of suspected meningitis in patients who have a known allergy to penicillin, and the prescription or PSO is endorsed accordingly.

Inj 500 mg vial	1.20	1	✓	DEVA
Inj 1 g vial	0.84	1	✓	DEVA

CEFUROXIME AXETIL – Subsidy by endorsement

Only if prescribed for prophylaxis of endocarditis and the prescription is endorsed accordingly.

Tab 250 mg	29.40	50	✓	Zinnat
------------------	-------	----	---	---------------

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
--	---	------------------------------	-------------------------------------

Macrolides

AZITHROMYCIN – Maximum of 5 days treatment per prescription; can be waived by Special Authority see [SA1683 below](#)

A maximum of 24 months of azithromycin treatment for non-cystic fibrosis bronchiectasis will be subsidised on Special Authority.

Tab 250 mg	8.19	30	✓ Apo-Azithromycin
	8.50	6	✓ Zithromax
Tab 500 mg – Up to 8 tab available on a PSO	0.93	2	✓ Apo-Azithromycin
Grans for oral liq 200 mg per 5 ml (40 mg per ml) – Wastage claimable	14.38	15 ml	✓ Zithromax

Zithromax to be Sole Supply on 1 January 2019

►SA1683 Special Authority for Waiver of Rule

Initial application — (bronchiolitis obliterans syndrome, cystic fibrosis and atypical Mycobacterium infections) only from a relevant specialist. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Any of the following:

- 1 Patient has received a lung transplant, stem cell transplant, or bone marrow transplant and requires treatment for bronchiolitis obliterans syndrome*; or
- 2 Patient has received a lung transplant and requires prophylaxis for bronchiolitis obliterans syndrome*; or
- 3 Patient has cystic fibrosis and has chronic infection with *Pseudomonas aeruginosa* or *Pseudomonas*-related gram negative organisms*; or
- 4 Patient has an atypical *Mycobacterium* infection.

Note: Indications marked with * are unapproved indications.

Initial application — (non-cystic fibrosis bronchiectasis*) only from a respiratory specialist or paediatrician. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 For prophylaxis of exacerbations of non-cystic fibrosis bronchiectasis*; and
- 2 Patient is aged 18 and under; and
- 3 Either:
 - 3.1 Patient has had 3 or more exacerbations of their bronchiectasis, within a 12 month period; or
 - 3.2 Patient has had 3 acute admissions to hospital for treatment of infective respiratory exacerbations within a 12 month period.

Note: Indications marked with * are unapproved indications.

Renewal — (non-cystic fibrosis bronchiectasis*) only from a respiratory specialist or paediatrician. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient has completed 12 months of azithromycin treatment for non-cystic fibrosis bronchiectasis; and
- 2 Following initial 12 months of treatment, the patient has not received any further azithromycin treatment for non-cystic fibrosis bronchiectasis for a further 12 months, unless considered clinically inappropriate to stop treatment; and
- 3 The patient will not receive more than a total of 24 months' azithromycin cumulative treatment (see note).

The patient must not have had more than 1 prior approval.

Note: No further renewals will be subsidised. A maximum of 24 months of azithromycin treatment for non-cystic fibrosis bronchiectasis will be subsidised. Indications marked with * are unapproved indications

CLARITHROMYCIN – Maximum of 500 mg per prescription; can be waived by Special Authority see [SA1131 below](#)

Tab 250 mg	3.98	14	✓ Apo-Clarithromycin
Grans for oral liq 250 mg per 5 ml – Wastage claimable.....	23.12	50 ml	✓ Klacid

►SA1131 Special Authority for Waiver of Rule

Initial application — (Mycobacterial infections) only from a respiratory specialist, infectious disease specialist or paediatrician.

continued...

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
continued...				
Approvals valid for 2 years for applications meeting the following criteria:				
Either:				
1 Atypical mycobacterial infection; or				
2 Mycobacterium tuberculosis infection where there is drug-resistance or intolerance to standard pharmaceutical agents.				
Renewal — (Mycobacterial infections) only from a respiratory specialist, infectious disease specialist or paediatrician.				
Approvals valid for 2 years where the treatment remains appropriate and the patient is benefiting from treatment.				
ERYTHROMYCIN ETHYL SUCCINATE				
Tab 400 mg	16.95	100	✓	E-Mycin
a) Up to 20 tab available on a PSO				
b) Up to 2 x the maximum PSO quantity for RFPP				
Grans for oral liq 200 mg per 5 ml	5.00	100 ml	✓	E-Mycin
a) Up to 300 ml available on a PSO				
b) Up to 2 x the maximum PSO quantity for RFPP				
c) Wastage claimable				
Grans for oral liq 400 mg per 5 ml	6.77	100 ml	✓	E-Mycin
a) Up to 200 ml available on a PSO				
b) Wastage claimable				
ERYTHROMYCIN LACTOBIONATE				
Inj 1 g	16.00	1	✓	Erythrocin IV
ERYTHROMYCIN STEARATE				
Tab 250 mg – Up to 30 tab available on a PSO	14.95	100		ERA
	(22.29)			
Tab 500 mg	29.90	100		ERA
	(44.58)			
ROXITHROMYCIN				
Tab disp 50 mg	7.19	10	✓	Rulide D
Restricted to children under 12 years of age.				
Tab 150 mg	7.48	50	✓	Arrow-Roxithromycin
Tab 300 mg	14.40	50	✓	Arrow-Roxithromycin

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
Penicillins				
AMOXICILLIN				
Cap 250 mg	14.97	500	✓	Apo-Amoxi
a) Up to 30 cap available on a PSO				
b) Up to 10 x the maximum PSO quantity for RFPP				
Cap 500 mg	16.75	500	✓	Apo-Amoxi
a) Up to 30 cap available on a PSO				
b) Up to 10 x the maximum PSO quantity for RFPP				
Grans for oral liq 125 mg per 5 ml	1.20	100 ml	✓	Alphamox 125
a) Up to 200 ml available on a PSO				
b) Wastage claimable				
Grans for oral liq 250 mg per 5 ml	1.31	100 ml	✓	Alphamox 250
a) Up to 300 ml available on a PSO				
b) Up to 10 x the maximum PSO quantity for RFPP				
c) Wastage claimable				
Inj 250 mg vial	10.67	10	✓	Ibiamox
Inj 500 mg vial	12.41	10	✓	Ibiamox
Inj 1 g vial – Up to 5 inj available on a PSO	17.29	10	✓	Ibiamox
AMOXICILLIN WITH CLAVULANIC ACID				
Tab 500 mg with clavulanic acid 125 mg – Up to 30 tab available on a PSO	1.88	20	✓	Augmentin
Grans for oral liq amoxicillin 25 mg with clavulanic acid 6.25 mg per ml	3.83	100 ml	✓	Augmentin
a) Up to 200 ml available on a PSO				
b) Wastage claimable				
Grans for oral liq amoxicillin 50 mg with clavulanic acid 12.5 mg per ml – Up to 200 ml available on a PSO	2.20	100 ml OP	✓	Curam
BENZATHINE BENZYL PENICILLIN				
Inj 900 mg (1.2 million units) in 2.3 ml syringe – Up to 5 inj available on a PSO	344.93	10	✓	Bicillin LA
Bicillin LA to be Sole Supply on 1 January 2019				
BENZYL PENICILLIN SODIUM [PENICILLIN G]				
Inj 600 mg (1 million units) vial – Up to 5 inj available on a PSO	10.35	10	✓	Sandoz
FLUCLOXACILLIN				
Cap 250 mg – Up to 30 cap available on a PSO	16.83	250	✓	Staphlex
Cap 500 mg	56.61	500	✓	Staphlex
Grans for oral liq 25 mg per ml	2.29	100 ml	✓	AFT
a) Up to 200 ml available on a PSO				
b) Wastage claimable				
Grans for oral liq 50 mg per ml	3.68	100 ml	✓	AFT
a) Up to 200 ml available on a PSO				
b) Wastage claimable				
Inj 250 mg vial	9.00	10	✓	Flucloxin
Inj 500 mg vial	9.40	10	✓	Flucloxin
Inj 1 g vial – Up to 5 inj available on a PSO	5.22	5	✓	Flucil

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

* Three months or six months, as applicable, dispensed all-at-once

INFECTIONS - AGENTS FOR SYSTEMIC USE

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
PHENOXYMETHYLPENICILLIN (PENICILLIN V)				
Cap 250 mg – Up to 30 cap available on a PSO	2.59	50	✓	Cilicaine VK
Cap 500 mg	4.26	50	✓	Cilicaine VK
a) Up to 20 cap available on a PSO				
b) Up to 2 x the maximum PSO quantity for RFPP				
Grans for oral liq 125 mg per 5 ml	1.48	100 ml	✓	AFT
a) Up to 200 ml available on a PSO				
b) Wastage claimable				
Grans for oral liq 250 mg per 5 ml	1.58	100 ml	✓	AFT
a) Up to 300 ml available on a PSO				
b) Up to 2 x the maximum PSO quantity for RFPP				
c) Wastage claimable				
PROCAINE PENICILLIN				
Inj 1.5 g in 3.4 ml syringe – Up to 5 inj available on a PSO	123.50	5	✓	Cilicaine

Tetracyclines

DOXYCYCLINE				
* Tab 50 mg – Up to 30 tab available on a PSO	2.90 (6.00)	30		Doxy-50
* Tab 100 mg – Up to 30 tab available on a PSO	6.75	250	✓	Doxine
MINOCYCLINE HYDROCHLORIDE				
* Tab 50 mg – Additional subsidy by Special Authority see SA1355 below – Retail pharmacy	5.79 (12.05)	60		Mino-tabs
* Cap 100 mg	19.32 (52.04)	100		Minomycin

➡ SA1355 Special Authority for Manufacturers Price

Initial application from any relevant practitioner. Approvals valid without further renewal unless notified where the patient has rosacea.

TETRACYCLINE – Special Authority see SA1332 below – Retail pharmacy

Cap 500 mg	46.00	30	✓	Tetracyclin Wolff S29
------------------	-------	----	---	----------------------------------

➡ SA1332 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 3 months for applications meeting the following criteria:

Both:

- 1 For the eradication of helicobacter pylori following unsuccessful treatment with appropriate first-line therapy; and
- 2 For use only in combination with bismuth as part of a quadruple therapy regimen.

Subsidy (Manufacturer's Price) \$	Fully Subsidised ✓	Brand or Generic Manufacturer
Per		

Other Antibiotics

For topical antibiotics, refer to DERMATOLOGICALS, page 62

CIPROFLOXACIN

Recommended for patients with any of the following:

- microbiologically confirmed and clinically significant pseudomonas infection; or
- prostatitis; or
- pyelonephritis; or
- gonorrhoea.

Tab 250 mg – Up to 5 tab available on a PSO	1.45	28	✓ Cipflox
Tab 500 mg – Up to 5 tab available on a PSO	1.99	28	✓ Cipflox
Tab 750 mg	3.15	28	✓ Cipflox

CLINDAMYCIN

Cap hydrochloride 150 mg – Maximum of 4 cap per prescription; can be waived by endorsement - Retail pharmacy - Specialist

4.10 16 ✓ **Clindamycin ABM**

Inj phosphate 150 mg per ml, 4 ml ampoule – Retail pharmacy-Specialist

65.00 10 ✓ **Dalacin C**

COLISTIN SULPHOMETHATE – Retail pharmacy-Specialist – Subsidy by endorsement

Only if prescribed for dialysis or cystic fibrosis patient and the prescription is endorsed accordingly.

Inj 150 mg

65.00 1 ✓ **Colistin-Link**

GENTAMICIN SULPHATE

Inj 10 mg per ml, 1 ml ampoule – Subsidy by endorsement.....

25.00 5 ✓ **DBL Gentamicin**

Only if prescribed for a dialysis or cystic fibrosis patient or complicated urinary tract infection and the prescription is endorsed accordingly.

Inj 10 mg per ml, 2 ml – Subsidy by endorsement

62.00 5 ✓ **Wockhardt S29**

175.10 25 ✓ **APP**

Pharmaceuticals S29

Only if prescribed for a dialysis or cystic fibrosis patient or complicated urinary tract infection and the prescription is endorsed accordingly.

Inj 40 mg per ml, 2 ml ampoule – Subsidy by endorsement.....

6.00 10 ✓ **Pfizer**

Only if prescribed for a dialysis or cystic fibrosis patient or complicated urinary tract infection and the prescription is endorsed accordingly.

(Wockhardt S29 Inj 10 mg per ml, 2 ml to be delisted 1 April 2019)

(APP Pharmaceuticals S29 Inj 10 mg per ml, 2 ml to be delisted 1 April 2019)

MOXIFLOXACIN – Special Authority see SA1740 below – Retail pharmacy

No patient co-payment payable

Tab 400 mg

52.00 5 ✓ **Avelox**

►SA1740 Special Authority for Subsidy

Initial application — (Tuberculosis) only from a respiratory specialist or infectious disease specialist. Approvals valid for 1 year for applications meeting the following criteria:

Any of the following:

1 Both:

1.1 Active tuberculosis*; and

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

1.2 Any of the following:

- 1.2.1 Documented resistance to one or more first-line medications; or
- 1.2.2 Suspected resistance to one or more first-line medications (tuberculosis assumed to be contracted in an area with known resistance), as part of regimen containing other second-line agents; or
- 1.2.3 Impaired visual acuity (considered to preclude ethambutol use); or
- 1.2.4 Significant pre-existing liver disease or hepatotoxicity from tuberculosis medications; or
- 1.2.5 Significant documented intolerance and/or side effects following a reasonable trial of first-line medications; or

- 2 Mycobacterium avium-intracellulare complex not responding to other therapy or where such therapy is contraindicated.*; or
- 3 Patient is under five years of age and has had close contact with a confirmed multi-drug resistant tuberculosis case.

Note: Indications marked with * are unapproved indications.

Renewal only from a respiratory specialist or infectious disease specialist. Approvals valid for 1 year where the treatment remains appropriate and the patient is benefiting from treatment.

Initial application — (Mycoplasma genitalium) only from a sexual health specialist or Practitioner on the recommendation of a sexual health specialist. Approvals valid for 1 month for applications meeting the following criteria:

All of the following:

- 1 Has nucleic acid amplification test (NAAT) confirmed Mycoplasma genitalium* and is symptomatic; and
- 2 Either:
 - 2.1 Has tried and failed to clear infection using azithromycin; or
 - 2.2 Has laboratory confirmed azithromycin resistance; and
- 3 Treatment is only for 7 days.

Initial application — (Penetrating eye injury) only from an ophthalmologist. Approvals valid for 1 month where the patient requires prophylaxis following a penetrating eye injury and treatment is for 5 days only.

Note: Indications marked with * are unapproved indications.

PAROMOMYCIN – Special Authority see [SA1689 below](#) – Retail pharmacy

Cap 250 mg.....	126.00	16	✓ Humatin ^{S29}
-----------------	--------	----	--------------------------

►SA1689 Special Authority for Subsidy

Initial application only from an infectious disease specialist, clinical microbiologist or gastroenterologist. Approvals valid for 1 month for applications meeting the following criteria:

Either:

- 1 Patient has confirmed cryptosporidium infection; or
- 2 For the eradication of Entamoeba histolytica carriage.

Renewal only from an infectious disease specialist, clinical microbiologist or gastroenterologist. Approvals valid for 1 month for applications meeting the following criteria:

Either:

- 1 Patient has confirmed cryptosporidium infection; or
- 2 For the eradication of Entamoeba histolytica carriage.

PYRIMETHAMINE – Special Authority see [SA1328 below](#) – Retail pharmacy

Tab 25 mg	26.14	30	✓ Daraprim ^{S29}
	36.95	50	✓ Daraprim ^{S29}

►SA1328 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Any of the following:

- 1 For the treatment of toxoplasmosis in patients with HIV for a period of 3 months; or
- 2 For pregnant patients for the term of the pregnancy; or
- 3 For infants with congenital toxoplasmosis until 12 months of age.

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
SODIUM FUSIDATE [FUSIDIC ACID]				
Tab 250 mg – Retail pharmacy-Specialist.....	34.50	12	✓	Fucidin
Prescriptions must be written by, or on the recommendation of, an infectious disease physician or a clinical microbiologist				

SULFADIAZINE SODIUM – Special Authority see [SA1331 below](#) – Retail pharmacy

Tab 500 mg	543.20	56	✓	Wockhardt S29
------------------	--------	----	---	----------------------

► **SA1331 Special Authority for Subsidy**

Initial application from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Any of the following:

- For the treatment of toxoplasmosis in patients with HIV for a period of 3 months; or
- For pregnant patients for the term of the pregnancy; or
- For infants with congenital toxoplasmosis until 12 months of age.

TOBRAMYCIN

Inj 40 mg per ml, 2 ml vial – Subsidy by endorsement.....	15.00	5	✓	Tobramycin Mylan
Only if prescribed for dialysis or cystic fibrosis patient and the prescription is endorsed accordingly.				
Solution for inhalation 60 mg per ml, 5 ml – Subsidy by endorsement.....	2,200.00	56 dose	✓	TOBI
a) Wastage claimable				
b) Only if prescribed for a cystic fibrosis patient and the prescription is endorsed accordingly.				

TRIMETHOPRIM

* Tab 300 mg – Up to 30 tab available on a PSO.....	16.50	50	✓	TMP
---	-------	----	---	------------

TRIMETHOPRIM WITH SULPHAMETHOXAZOLE [CO-TRIMOXAZOLE]

* Tab trimethoprim 80 mg and sulphamethoxazole 400 mg – Up to 30 tab available on a PSO.....	22.90	500	✓	Trisul
* Oral liq 8 mg sulphamethoxazole 40 mg per ml – Up to 200 ml available on a PSO.....	2.97	100 ml	✓	Deprim

VANCOMYCIN – Subsidy by endorsement

Only if prescribed for a dialysis or cystic fibrosis patient or for prophylaxis of endocarditis or for treatment of Clostridium difficile following metronidazole failure and the prescription is endorsed accordingly.

Inj 500 mg vial	2.37	1	✓	Mylan
-----------------------	------	---	---	--------------

Antifungals

- For topical antifungals refer to DERMATOLOGICALS, [page 62](#)
- For topical antifungals refer to GENITO URINARY, [page 75](#)

FLUCONAZOLE

Cap 50 mg – Retail pharmacy-Specialist	2.09	28	✓	Mylan
Cap 150 mg – Subsidy by endorsement	0.33	1	✓	Mylan
a) Maximum of 1 cap per prescription; can be waived by endorsement - Retail pharmacy - Specialist				
b) Patient has vaginal candida albicans and the practitioner considers that a topical imidazole (used intra-vaginally) is not recommended and the prescription is endorsed accordingly; can be waived by endorsement - Retail pharmacy - Specialist.				
Cap 200 mg – Retail pharmacy-Specialist	5.08	28	✓	Mylan
Powder for oral suspension 10 mg per ml – Special Authority see SA1359 on the next page – Retail pharmacy	34.56	35 ml	✓	Diflucan S29
	98.50		✓	Diflucan
Wastage claimable				

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
---	----------------------------	-------------------------------------

►SA1359 Special Authority for Subsidy

Initial application — (Systemic candidiasis) from any relevant practitioner. Approvals valid for 6 weeks for applications meeting the following criteria:

Both:

- 1 Patient requires prophylaxis for, or treatment of systemic candidiasis; and
- 2 Patient is unable to swallow capsules.

Initial application — (Immunocompromised) from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient is immunocompromised; and
- 2 Patient is at moderate to high risk of invasive fungal infection; and
- 3 Patient is unable to swallow capsules.

Renewal — (Systemic candidiasis) from any relevant practitioner. Approvals valid for 6 weeks for applications meeting the following criteria:

Both:

- 1 Patient requires prophylaxis for, or treatment of systemic candidiasis; and
- 2 Patient is unable to swallow capsules.

Renewal — (Immunocompromised) from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient remains immunocompromised; and
- 2 Patient remains at moderate to high risk of invasive fungal infection; and
- 3 Patient is unable to swallow capsules.

ITRACONAZOLE

Cap 100 mg – Subsidy by endorsement	2.79	15	✓ Itrazole
Funded for tinea versicolor where topical treatment has not been successful and diagnosis has been confirmed by mycology, or for tinea unguium where terbinafine has not been successful in eradication or the patient is intolerant to terbinafine and diagnosis has been confirmed by mycology and the prescription is endorsed accordingly. Can be waived by endorsement - Retail pharmacy - Specialist Specialist must be an infectious disease physician, clinical microbiologist, clinical immunologist or dermatologist.			
Oral liq 10 mg per ml – Special Authority see SA1322 below –			
Retail pharmacy.....	141.80	150 ml OP	✓ Sporanox

►SA1322 Special Authority for Subsidy

Initial application only from an infectious disease specialist, clinical microbiologist, clinical immunologist or any relevant practitioner on the recommendation of a infectious disease physician, clinical microbiologist or clinical immunologist. Approvals valid for 6 months where the patient has a congenital immune deficiency.

Renewal from any relevant practitioner. Approvals valid for 6 months where the treatment remains appropriate and the patient is benefitting from the treatment.

KETOCONAZOLE

Tab 200 mg – PCT – Retail pharmacy-Specialist – Subsidy by endorsement.....	CBS	30	✓ Link Healthcare <small>\$29</small>
			✓ Nizoral <small>\$29</small>

Prescriptions must be written by, or on the recommendation of an oncologist

NYSTATIN

Tab 500,000 u	14.16 (17.09)	50	Nilstat
Cap 500,000 u	12.81 (15.47)	50	Nilstat

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
POSACONAZOLE – Special Authority see SA1285 below – Retail pharmacy				
Tab modified-release 100 mg	869.86	24	✓	Noxafil
Oral liq 40 mg per ml	761.13	105 ml OP	✓	Noxafil

► **SA1285 Special Authority for Subsidy**

Initial application only from a haematologist or infectious disease specialist. Approvals valid for 6 weeks for applications meeting the following criteria:

Either:

- 1 Patient has acute myeloid leukaemia and is to be treated with high dose remission induction, re-induction or consolidation chemotherapy; or
- 2 Patient has received a stem cell transplant and has graft versus host disease and is on significant immunosuppressive therapy*.

Renewal only from a haematologist or infectious disease specialist. Approvals valid for 6 weeks for applications meeting the following criteria:

Either:

- 1 Patient has acute myeloid leukaemia and is to be treated with high dose remission induction, re-induction or consolidation therapy; or
- 2 Patient has received a stem cell transplant and has graft versus host disease and is on significant immunosuppression* and requires on going posaconazole treatment.

Note: * Graft versus host disease (GVHD) on significant immunosuppression is defined as acute GVHD, grade II to IV, or extensive chronic GVHD, or if they were being treated with intensive immunosuppressive therapy consisting of either high-dose corticosteroids (1 mg or greater per kilogram of body weight per day for patients with acute GVHD or 0.8 mg or greater per kilogram every other day for patients with chronic GVHD), antithymocyte globulin, or a combination of two or more immunosuppressive agents or types of treatment.

TERBINAFINE

* Tab 250 mg 1.33 14 ✓ **Deolatte**

VORICONAZOLE – Special Authority see [SA1273 below](#) – Retail pharmacy

Tab 50 mg 91.00 56 ✓ **Vttack**

Tab 200 mg 350.00 56 ✓ **Vttack**

Powder for oral suspension 40 mg per ml – Wastage

claimable 1,437.00 70 ml ✓ **Vfend**

Vfend to be Sole Supply on 1 January 2019

► **SA1273 Special Authority for Subsidy**

Initial application — (invasive fungal infection) only from a haematologist, infectious disease specialist or clinical microbiologist. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 Patient is immunocompromised; and
- 2 Applicant is part of a multidisciplinary team including an infectious disease specialist; and
- 3 Any of the following:
 - 3.1 Patient has proven or probable invasive aspergillus infection; or
 - 3.2 Patient has possible invasive aspergillus infection; or
 - 3.3 Patient has fluconazole resistant candidiasis; or
 - 3.4 Patient has mould strain such as Fusarium spp. and Scedosporium spp.

Renewal — (invasive fungal infection) only from a haematologist, infectious disease specialist or clinical microbiologist.

Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 Patient is immunocompromised; and
- 2 Applicant is part of a multidisciplinary team including an infectious disease specialist; and

continued...

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

* Three months or six months, as applicable, dispensed all-at-once

INFECTIONS - AGENTS FOR SYSTEMIC USE

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

3 Any of the following:

- 3.1 Patient continues to require treatment for proven or probable invasive aspergillus infection; or
- 3.2 Patient continues to require treatment for possible invasive aspergillus infection; or
- 3.3 Patient has fluconazole resistant candidiasis; or
- 3.4 Patient has mould strain such as Fusarium spp. and Scedosporium spp.

Antimalarials

PRIMAQUINE PHOSPHATE – Special Authority see [SA1684 below](#) – Retail pharmacy

Tab 7.5 mg 117.00 56 ✓ **Primacin** \$29

» [SA1684](#) **Special Authority for Subsidy**

Initial application only from an infectious disease specialist or clinical microbiologist. Approvals valid for 1 month for applications meeting the following criteria:

Both:

- 1 The patient has vivax or ovale malaria; and
- 2 Primaquine is to be given for a maximum of 21 days.

Renewal only from an infectious disease specialist or clinical microbiologist. Approvals valid for 1 month for applications meeting the following criteria:

Both:

- 1 The patient has relapsed vivax or ovale malaria; and
- 2 Primaquine is to be given for a maximum of 21 days.

Antiparasitics

Antiprotozoals

QUININE SULPHATE

* Tab 300 mg 61.91 500 ✓ **Q 300**

Antitrichomonal Agents

METRONIDAZOLE

Tab 200 mg – Up to 30 tab available on a PSO 10.45 100 ✓ **Trichazole**
 Tab 400 mg – Up to 15 tab available on a PSO 18.15 100 ✓ **Trichazole**
 Oral liq benzoate 200 mg per 5 ml 25.00 100 ml ✓ **Flagyl-S**
 Suppos 500 mg 24.48 10 ✓ **Flagyl**

ORNIDAZOLE

Tab 500 mg 23.00 10 ✓ **Arrow-Ornidazole**

Antituberculotics and Antileprotics

Note: There is no co-payment charge for all pharmaceuticals listed in the Antituberculotics and Antileprotics group regardless of immigration status.

CLOFAZIMINE – Retail pharmacy-Specialist

- a) No patient co-payment payable
- b) Prescriptions must be written by, or on the recommendation of, an infectious disease physician, clinical microbiologist or dermatologist.

* Cap 50 mg 442.00 100 ✓ **Lamprene** \$29

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
CYCLOSERINE – Retail pharmacy-Specialist				
a) No patient co-payment payable				
b) Prescriptions must be written by, or on the recommendation of, an infectious disease physician, clinical microbiologist or respiratory physician.				
Cap 250 mg	1,294.50	100	✓ King	S29
DAPSONE – Retail pharmacy-Specialist				
a) No patient co-payment payable				
b) Prescriptions must be written by, or on the recommendation of, an infectious disease physician, clinical microbiologist or dermatologist				
Tab 25 mg	268.50	100	✓ Dapsone	
Tab 100 mg	329.50	100	✓ Dapsone	
ETHAMBUTOL HYDROCHLORIDE – Retail pharmacy-Specialist				
a) No patient co-payment payable				
b) Prescriptions must be written by, or on the recommendation of, an infectious disease physician, clinical microbiologist or respiratory physician				
Tab 100 mg	48.01	56	✓ Myambutol	S29
	85.73	100	✓ EMB Fato1	S29
Tab 400 mg	49.34	56	✓ Myambutol	S29
<i>(Myambutol S29 Tab 100 mg to be delisted 1 February 2019)</i>				
ISONIAZID – Retail pharmacy-Specialist				
a) No patient co-payment payable				
b) Prescriptions must be written by, or on the recommendation of, an internal medicine physician, paediatrician, clinical microbiologist, dermatologist or public health physician				
* Tab 100 mg	22.00	100	✓ PSM	
ISONIAZID WITH RIFAMPICIN – Retail pharmacy-Specialist				
a) No patient co-payment payable				
b) Prescriptions must be written by, or on the recommendation of, an internal medicine physician, paediatrician, clinical microbiologist, dermatologist or public health physician				
* Tab 100 mg with rifampicin 150 mg.....	85.54	100	✓ Rifinah	
* Tab 150 mg with rifampicin 300 mg.....	170.60	100	✓ Rifinah	
PARA-AMINO SALICYLIC ACID – Retail pharmacy-Specialist				
a) No patient co-payment payable				
b) Specialist must be an infectious disease specialist, clinical microbiologist or respiratory specialist.				
Grans for oral liq 4 g sachet	280.00	30	✓ Paser	S29
PROTIONAMIDE – Retail pharmacy-Specialist				
a) No patient co-payment payable				
b) Specialist must be an infectious disease specialist, clinical microbiologist or respiratory specialist.				
Tab 250 mg	305.00	100	✓ Pete1a	S29
PYRAZINAMIDE – Retail pharmacy-Specialist				
a) No patient co-payment payable				
b) Prescriptions must be written by, or on the recommendation of, an infectious disease physician, clinical microbiologist or respiratory physician				
* Tab 500 mg	59.00	100	✓ AFT-Pyrazinamide	
			✓ AFT-Pyrazinamide	S29

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
RIFABUTIN – Retail pharmacy-Specialist				
a) No patient co-payment payable				
b) Prescriptions must be written by, or on the recommendation of, an infectious disease physician, respiratory physician or gastroenterologist				
* Cap 150 mg.....	275.00	30	✓	Mycobutin
RIFAMPICIN – Subsidy by endorsement				
a) No patient co-payment payable				
b) For confirmed recurrent <i>Staphylococcus aureus</i> infection in combination with other effective anti-staphylococcal antimicrobial based on susceptibilities and the prescription is endorsed accordingly; can be waived by endorsement - Retail pharmacy - Specialist. Specialist must be an internal medicine physician, clinical microbiologist, dermatologist, paediatrician, or public health physician.				
* Cap 150 mg.....	55.75	100	✓	Rifadin
* Cap 300 mg.....	116.25	100	✓	Rifadin
* Oral liq 100 mg per 5 ml.....	12.00	60 ml	✓	Rifadin

Antivirals

For eye preparations refer to Eye Preparations, Anti-Infective Preparations, [page 208](#)

Hepatitis B Treatment

ADEFOVIR DIPVOXIL – Special Authority see [SA0829 below](#) – Retail pharmacy

Tab 10 mg	670.00	30	✓	Hepsera
-----------------	--------	----	---	----------------

➔SA0829 Special Authority for Subsidy

Initial application only from a gastroenterologist or infectious disease specialist. Approvals valid for 1 year for applications meeting the following criteria:

All of the following:

- 1 Patient has confirmed Hepatitis B infection (HBsAg+); and Documented resistance to lamivudine, defined as:
- 2 Patient has raised serum ALT ($> 1 \times \text{ULN}$); and
- 3 Patient has HBV DNA greater than 100,000 copies per mL, or viral load 10 fold or higher over nadir; and
- 4 Detection of M204I or M204V mutation; and
- 5 Either:
 - 5.1 Both:
 - 5.1.1 Patient is cirrhotic; and
 - 5.1.2 adefovir dipivoxil to be used in combination with lamivudine; or
 - 5.2 Both:
 - 5.2.1 Patient is not cirrhotic; and
 - 5.2.2 adefovir dipivoxil to be used as monotherapy.

Renewal only from a gastroenterologist or infectious disease specialist. Approvals valid for 2 years where in the opinion of the treating physician, treatment remains appropriate and patient is benefiting from treatment.

Notes: Lamivudine should be added to adefovir dipivoxil if a patient develops documented resistance to adefovir dipivoxil, defined as:

- i) raised serum ALT ($> 1 \times \text{ULN}$); and
- ii) HBV DNA greater than 100,000 copies per mL, or viral load 10 fold or higher over nadir; and
- iii) Detection of N236T or A181T/V mutation.

Adefovir dipivoxil should be stopped 6 months following HBeAg seroconversion for patients who were HBeAg+ prior to commencing adefovir dipivoxil.

The recommended dose of adefovir dipivoxil is no more than 10mg daily.

In patients with renal insufficiency adefovir dipivoxil dose should be reduced in accordance with the datasheet guidelines.

Adefovir dipivoxil should be avoided in pregnant women and children.

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
ENTECAVIR				
* Tab 0.5 mg	52.00 (400.00)	30	✓	Entecavir Sandoz Baraclude
<i>(Baraclude Tab 0.5 mg to be delisted 1 January 2019)</i>				
LAMIVUDINE – Special Authority see SA1685 below – Retail pharmacy				
Tab 100 mg	4.20	28	✓	Zetlam
Oral liq 5 mg per ml	270.00	240 ml OP	✓	Zeffix
➔SA1685 Special Authority for Subsidy				
Initial application only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist.				
Approvals valid for 1 year where used for the treatment or prevention of hepatitis B.				
Renewal from any relevant practitioner. Approvals valid for 2 years where used for the treatment or prevention of hepatitis B.				
TENOFOVIR DISOPROXIL – Brand switch fee payable (Pharmacode 2556642) - see page 213 for details				
Tenofovir disoproxil prescribed under endorsement for the treatment of HIV is included in the count of up to 4 subsidised antiretrovirals for the purposes of Special Authority SA1651., page 106				
* Tab 245 mg (300.6 mg as a succinate)	38.10	30	✓	Tenofovir Disoproxil Teva

Herpesvirus Treatments

ACICLOVIR				
* Tab dispersible 200 mg	1.60	25	✓	Lovir
* Tab dispersible 400 mg	5.38	56	✓	Lovir
* Tab dispersible 800 mg	5.98	35	✓	Lovir
VALACICLOVIR				
Tab 500 mg	5.75	30	✓	Vaclovir
Tab 1,000 mg	11.35	30	✓	Vaclovir
VALGANCICLOVIR – Special Authority see SA1404 below – Retail pharmacy				
Tab 450 mg	1,050.00	60	✓	Valcyte
➔SA1404 Special Authority for Subsidy				
Initial application — (transplant cytomegalovirus prophylaxis) only from a relevant specialist. Approvals valid for 3 months where the patient has undergone a solid organ transplant and requires valganciclovir for CMV prophylaxis.				
Renewal — (transplant cytomegalovirus prophylaxis) only from a relevant specialist. Approvals valid for 3 months for applications meeting the following criteria:				
Both:				
1 Patient has undergone a solid organ transplant and received anti-thymocyte globulin and requires valganciclovir therapy for CMV prophylaxis; and				
2 Patient is to receive a maximum of 90 days of valganciclovir prophylaxis following anti-thymocyte globulin.				
Initial application — (cytomegalovirus prophylaxis following anti-thymocyte globulin) only from a relevant specialist.				
Approvals valid for 3 months for applications meeting the following criteria:				
Both:				
1 Patient has undergone a solid organ transplant and received valganciclovir under Special Authority more than 2 years ago (27 months); and				
2 Patient has received anti-thymocyte globulin and requires valganciclovir for CMV prophylaxis.				
Renewal — (cytomegalovirus prophylaxis following anti-thymocyte globulin) only from a relevant specialist. Approvals valid for 3 months where the patient has received a further course of anti-thymocyte globulin and requires valganciclovir for CMV prophylaxis.				
Initial application — (Lung transplant cytomegalovirus prophylaxis) only from a relevant specialist. Approvals valid for 6 months for applications meeting the following criteria:				

continued...

continued...

Both:

- 1 Patient has undergone a lung transplant; and
- 2 Either:
 - 2.1 The donor was cytomegalovirus positive and the patient is cytomegalovirus negative; or
 - 2.2 The recipient is cytomegalovirus positive.

Initial application — (Cytomegalovirus in immunocompromised patients) only from a relevant specialist. Approvals valid for 3 months for applications meeting the following criteria:

Both:

- 1 Patient is immunocompromised; and
- 2 Any of the following:
 - 2.1 Patient has cytomegalovirus syndrome or tissue invasive disease; or
 - 2.2 Patient has rapidly rising plasma CMV DNA in absence of disease; or
 - 2.3 Patient has cytomegalovirus retinitis.

Renewal — (Cytomegalovirus in immunocompromised patients) only from a relevant specialist. Approvals valid for 3 months for applications meeting the following criteria:

Both:

- 1 Patient is immunocompromised; and
- 2 Any of the following:
 - 2.1 Patient has cytomegalovirus syndrome or tissue invasive disease; or
 - 2.2 Patient has rapidly rising plasma CMV DNA in absence of disease; or
 - 2.3 Patient has cytomegalovirus retinitis.

Note: for the purpose of this Special Authority "immunocompromised" includes transplant recipients, patients with immunosuppressive diseases (e.g. HIV) or those receiving immunosuppressive treatment for other conditions.

Hepatitis C Treatment

LEDIPASVIR WITH SOFOSBUVIR – Special Authority see [SA1605 below](#) – [Xpharm]

No patient co-payment payable

Tab 90 mg with sofosbuvir 400 mg.....	24,363.46	28	✓ Harvoni
---------------------------------------	-----------	----	-----------

➔SA1605 Special Authority for Subsidy

Special Authority approved by the Hepatitis C Treatment Panel (HepCTP)

Notes: By application to the Hepatitis C Treatment Panel (HepCTP).

Applications will be considered by HepCTP and approved subject to confirmation of eligibility.

Application details may be obtained from PHARMAC's website <http://www.pharmac.govt.nz/hepatitis-c-treatments> or:

The Coordinator, Hepatitis C Treatment Panel

PHARMAC, PO Box 10-254, WELLINGTON Tel: (04) 460 4990,

Email: hepcpanel@pharmac.govt.nz

PARITAPREVIR, RITONAVIR AND OMBITASVIR WITH DASABUVIR – [Xpharm]

- a) No patient co-payment payable
- b) Note – Supply of treatment is via PHARMAC's approved direct distribution supply. Application details for accessing treatment may be obtained from PHARMAC's website <http://www.pharmac.govt.nz/hepatitis-c-treatments>

Tab 75 mg with ritonavir 50 mg, and ombitasvir 12.5 mg (56), with dasabuvir tab 250 mg (56)	16,500.00	1 OP	✓ Viekira Pak
--	-----------	------	---------------

PARITAPREVIR, RITONAVIR AND OMBITASVIR WITH DASABUVIR AND RIBAVIRIN – [Xpharm]

- a) No patient co-payment payable
- b) Note – Supply of treatment is via PHARMAC's approved direct distribution supply. Application details for accessing treatment may be obtained from PHARMAC's website <http://www.pharmac.govt.nz/hepatitis-c-treatments>

Tab 75 mg with ritonavir 50 mg, and ombitasvir 12.5 mg (56) with dasabuvir tab 250 mg (56) and ribavirin tab 200 mg (168)	16,500.00	1 OP	✓ Viekira Pak-RBV
---	-----------	------	-------------------

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

HIV Prophylaxis and Treatment

EMTRICITABINE WITH TENOFOVIR DISOPROXIL FUMARATE – Subsidy by endorsement; can be waived by Special Authority see [SA1714 below](#)

Endorsement for treatment of HIV: Prescription is deemed to be endorsed if emtricitabine with tenofovir disoproxil fumarate is co-prescribed with another antiretroviral subsidised under Special Authority SA1651 and the prescription is annotated accordingly by the Pharmacist or endorsed by the prescriber.

Note: Emtricitabine with tenofovir disoproxil fumarate prescribed under endorsement for the treatment of HIV is included in the count of up to 4 subsidised antiretrovirals, and counts as two antiretroviral medications, for the purposes of Special Authority SA1651, [page 106](#) There is an approval process to become a named specialist to prescribe antiretroviral therapy in New Zealand. Further information is available on the PHARMAC website.

Tab 200 mg with tenofovir disoproxil fumarate 300 mg..... 190.02 30 ✓ Truvada

➔SA1714 Special Authority for Waiver of Rule

Initial application only from a named specialist or medical practitioner on the recommendation of a named specialist. Approvals valid for 3 months for applications meeting the following criteria:

Both:

- 1 Patient has tested HIV negative; and
- 2 Either:
 - 2.1 All of the following:
 - 2.1.1 Patient is male or transgender; and
 - 2.1.2 Patient has sex with men; and
 - 2.1.3 Patient is likely to have multiple episodes of condomless anal intercourse in the next 3 months; and
 - 2.1.4 Any of the following:
 - 2.1.4.1 Patient has had at least one episode of condomless receptive anal intercourse with one or more casual male partners in the last 3 months; or
 - 2.1.4.2 A diagnosis of rectal chlamydia, rectal gonorrhoea, or infectious syphilis within the last 3 months; or
 - 2.1.4.3 Patient has used methamphetamine in the last three months; or
 - 2.2 All of the following:
 - 2.2.1 Patient has a regular partner who has HIV infection; and
 - 2.2.2 Partner is either not on treatment or has a detectable viral load; and
 - 2.2.3 Condoms have not been consistently used.

Renewal from any relevant practitioner. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 Applicant has an up to date knowledge of the safety issues and is competent to prescribe pre-exposure prophylaxis; and
- 2 Patient has undergone testing for HIV, syphilis, and a full STI screen in the previous two weeks; and
- 3 Patient has had renal function testing (creatinine, phosphate and urine protein/creatinine ratio) within the last 12 months; and
- 4 Patient has received advice regarding the reduction of risk of HIV and sexually transmitted infections and how to reduce those risks; and
- 5 Patient has tested HIV negative; and
- 6 Either:
 - 6.1 All of the following:
 - 6.1.1 Patient is male or transgender; and
 - 6.1.2 Patient has sex with men; and
 - 6.1.3 Patient is likely to have multiple episodes of condomless anal intercourse in the next 3 months; and
 - 6.1.4 Any of the following:
 - 6.1.4.1 Patient has had at least one episode of condomless receptive anal intercourse with one or more casual male partners in the last 3 months; or

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

- 6.1.4.2 A diagnosis of rectal chlamydia, rectal gonorrhoea, or infectious syphilis within the last 3 months; or
- 6.1.4.3 Patient has used methamphetamine in the last three months; or
- 6.2 All of the following:
 - 6.2.1 Patient has a regular partner who has HIV infection; and
 - 6.2.2 Partner is either not on treatment or has a detectable viral load; and
 - 6.2.3 Condoms have not been consistently used.

Antiretrovirals

►SA1651 Special Authority for Subsidy

Initial application — (Confirmed HIV) only from a named specialist. Approvals valid without further renewal unless notified where the patient has confirmed HIV infection.

Notes: Tenofovir disoproxil fumarate prescribed under endorsement for HIV is included in the count of up to 4 subsidised antiretrovirals.

Subsidies apply for a combination of up to four antiretroviral medications. The combination of a protease inhibitor and low-dose ritonavir given as a booster (either as part of a combination product or separately) will be counted as one protease inhibitor for the purpose of accessing funding to antiretrovirals.

Renewal — (Confirmed HIV) only from a named specialist. Approvals valid without further renewal unless notified where the treatment remains appropriate and the patient is benefiting from treatment.

Initial application — (Prevention of maternal transmission) only from a named specialist. Approvals valid for 1 year for applications meeting the following criteria:

Either:

- 1 Prevention of maternal foetal transmission; or
- 2 Treatment of the newborn for up to eight weeks.

Notes: Tenofovir disoproxil fumarate prescribed under endorsement for HIV is included in the count of up to 4 subsidised antiretrovirals.

Subsidies apply for a combination of up to four antiretroviral medications. The combination of a protease inhibitor and low-dose ritonavir given as a booster (either as part of a combination product or separately) will be counted as one protease inhibitor for the purpose of accessing funding to antiretrovirals.

Some antiretrovirals are unapproved or contraindicated for this indication. Practitioners prescribing these medications should exercise their own skill, judgement, expertise and discretion, and make their own prescribing decisions with respect to the use of a Pharmaceutical for an indication for which it is not approved or contraindicated.

Initial application — (post-exposure prophylaxis following non-occupational exposure to HIV) only from a named specialist. Approvals valid for 4 weeks for applications meeting the following criteria:

Both:

- 1 Treatment course to be initiated within 72 hours post exposure; and
- 2 Any of the following:
 - 2.1 Patient has had unprotected receptive anal intercourse with a known HIV positive person; or
 - 2.2 Patient has shared intravenous injecting equipment with a known HIV positive person; or
 - 2.3 Patient has had non-consensual intercourse and the clinician considers that the risk assessment indicates prophylaxis is required.

Notes: Tenofovir disoproxil fumarate prescribed under endorsement for HIV is included in the count of up to 4 subsidised antiretrovirals.

Subsidies apply for a combination of up to four antiretroviral medications. The combination of a protease inhibitor and low-dose ritonavir given as a booster (either as part of a combination product or separately) will be counted as one protease inhibitor for the purpose of accessing funding to antiretrovirals.

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

Renewal — (second or subsequent post-exposure prophylaxis) only from a named specialist. Approvals valid for 4 weeks for applications meeting the following criteria:

Both:

- 1 Treatment course to be initiated within 72 hours post exposure; and
- 2 Any of the following:
 - 2.1 Patient has had unprotected receptive anal intercourse with a known HIV positive person; or
 - 2.2 Patient has shared intravenous injecting equipment with a known HIV positive person; or
 - 2.3 Patient has had non-consensual intercourse and the clinician considers that the risk assessment indicates prophylaxis is required.

Initial application — (Percutaneous exposure) only from a named specialist. Approvals valid for 6 weeks where the patient has percutaneous exposure to blood known to be HIV positive.

Notes: Tenofovir disoproxil fumarate prescribed under endorsement for HIV is included in the count of up to 4 subsidised antiretrovirals.

Subsidies apply for a combination of up to four antiretroviral medications. The combination of a protease inhibitor and low-dose ritonavir given as a booster (either as part of a combination product or separately) will be counted as one protease inhibitor for the purpose of accessing funding to antiretrovirals.

Renewal — (Second or subsequent percutaneous exposure) only from a named specialist. Approvals valid for 6 weeks where the patient has percutaneous exposure to blood known to be HIV positive.

Non-nucleosides Reverse Transcriptase Inhibitors

EFAVIRENZ – Special Authority see SA1651 on the previous page – Retail pharmacy			
Tab 50 mg	63.38	30	✓ Stocrin ^{S29}
Tab 200 mg	190.15	90	✓ Stocrin
Tab 600 mg	63.38	30	✓ Stocrin
Oral liq 30 mg per ml	145.79	180 ml OP	✓ Stocrin ^{S29}
ETRAVIRINE – Special Authority see SA1651 on the previous page – Retail pharmacy			
Tab 200 mg	770.00	60	✓ Intencele
NEVIRAPINE – Special Authority see SA1651 on the previous page – Retail pharmacy			
Tab 200 mg	60.00	60	✓ Nevirapine Alphapharm
Oral suspension 10 mg per ml.....	203.55	240 ml	✓ Viramune Suspension

Nucleosides Reverse Transcriptase Inhibitors

ABACAVIR SULPHATE – Special Authority see SA1651 on the previous page – Retail pharmacy			
Tab 300 mg	229.00	60	✓ Ziagen
Oral liq 20 mg per ml	256.31	240 ml OP	✓ Ziagen
ABACAVIR SULPHATE WITH LAMIVUDINE – Special Authority see SA1651 on the previous page – Retail pharmacy			
Note: abacavir with lamivudine (combination tablets) counts as two anti-retroviral medications for the purposes of the anti-retroviral Special Authority.			
Tab 600 mg with lamivudine 300 mg.....	427.29	30	✓ Kivexa
EFAVIRENZ WITH EMTRICITABINE AND TENOFOVIR DISOPROXIL FUMARATE – Special Authority see SA1651 on the previous page – Retail pharmacy			
Note: Efavirenz with emtricitabine and tenofovir disoproxil fumarate counts as three anti-retroviral medications for the purposes of the anti-retroviral Special Authority			
Tab 600 mg with emtricitabine 200 mg and tenofovir disoproxil fumarate 300 mg	237.52	30	✓ Atripla

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

INFECTIONS - AGENTS FOR SYSTEMIC USE

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
EMTRICITABINE – Special Authority see SA1651 on page 106 – Retail pharmacy				
Cap 200 mg.....	307.20	30	✓	Emtriva
LAMIVUDINE – Special Authority see SA1651 on page 106 – Retail pharmacy				
Tab 150 mg.....	52.50	60	✓	Lamivudine Alphapharm
Oral liq 10 mg per ml.....	102.50	240 ml OP	✓	3TC
ZIDOVUDINE [AZT] – Special Authority see SA1651 on page 106 – Retail pharmacy				
Cap 100 mg.....	152.25	100	✓	Retrovir
Oral liq 10 mg per ml.....	30.45	200 ml OP	✓	Retrovir
ZIDOVUDINE [AZT] WITH LAMIVUDINE – Special Authority see SA1651 on page 106 – Retail pharmacy				
Note: zidovudine [AZT] with lamivudine (combination tablets) counts as two anti-retroviral medications for the purposes of the anti-retroviral Special Authority.				
Tab 300 mg with lamivudine 150 mg.....	33.00	60	✓	Alphapharm

Protease Inhibitors

ATAZANAVIR SULPHATE – Special Authority see SA1651 on page 106 – Retail pharmacy				
Cap 150 mg.....	568.34	60	✓	Reyataz
Cap 200 mg.....	757.79	60	✓	Reyataz
DARUNAVIR – Special Authority see SA1651 on page 106 – Retail pharmacy				
Tab 400 mg.....	335.00	60	✓	Prezista
Tab 600 mg.....	476.00	60	✓	Prezista
LOPINAVIR WITH RITONAVIR – Special Authority see SA1651 on page 106 – Retail pharmacy				
Tab 100 mg with ritonavir 25 mg.....	183.75	60	✓	Kaletra
Tab 200 mg with ritonavir 50 mg.....	463.00	120	✓	Kaletra
Oral liq 80 mg with ritonavir 20 mg per ml.....	735.00	300 ml OP	✓	Kaletra
RITONAVIR – Special Authority see SA1651 on page 106 – Retail pharmacy				
Tab 100 mg.....	43.31	30	✓	Norvir

Strand Transfer Inhibitors

DOLUTEGRAVIR – Special Authority see SA1651 on page 106 – Retail pharmacy				
Tab 50 mg.....	1,090.00	30	✓	Tivicay
RALTEGRAVIR POTASSIUM – Special Authority see SA1651 on page 106 – Retail pharmacy				
Tab 400 mg.....	1,090.00	60	✓	Isentress

Immune Modulators

Guidelines for the use of interferon in the treatment of hepatitis C:

Physicians considering treatment of patients with hepatitis C should discuss cases with a gastroenterologist or an infectious disease physician. All subjects undergoing treatment require careful monitoring for side effects.

Patients should be otherwise fit.

Hepatocellular carcinoma should be excluded by ultrasound examination and alpha-fetoprotein level.

Criteria for Treatment

1) Diagnosis

- Anti-HCV positive on at least two occasions with a positive PCR for HCV-RNA and preferably confirmed by a supplementary RIBA test; or

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
	✓	

continued...

- PCR-RNA positive for HCV on at least 2 occasions if antibody negative; or
- Anti-HCV positive on at least two occasions with a positive supplementary RIBA test with a negative PCR for HCV RNA but with a liver biopsy consistent with 2(b) following.

Exclusion Criteria

- 1) Autoimmune liver disease. (Interferon may exacerbate autoimmune liver disease as well as other autoimmune diseases such as thyroid disease).
- 2) Pregnancy.
- 3) Neutropenia ($< 2.0 \times 10^9$) and/or thrombocytopenia.
- 4) Continuing alcohol abuse and/or continuing intravenous drug users.

Dosage

The current recommended dosage is 3 million units of interferon alfa-2a or interferon alfa-2b administered subcutaneously 3 times a week for 52 weeks (twelve months)

Exit Criteria

The patient's response to interferon treatment should be reviewed at either three or four months. Interferon treatment should be discontinued in patients who do not show a substantial reduction (50%) in their mean pre-treatment ALT level at this stage.

INTERFERON ALFA-2A – PCT – Retail pharmacy-Specialist

- a) See prescribing guideline [on the previous page](#)
- b) Prescriptions must be written by, or on the recommendation of, an internal medicine physician or ophthalmologist

Inj 3 m iu prefilled syringe.....	38.00	1	✓ Roferon-A
-----------------------------------	-------	---	--------------------

INTERFERON ALFA-2B – PCT – Retail pharmacy-Specialist

- a) See prescribing guideline [on the previous page](#)
- b) Prescriptions must be written by, or on the recommendation of, an internal medicine physician or ophthalmologist

Inj 18 m iu, 1.2 ml multidose pen.....	206.71	1	✓ Intron-A
Inj 30 m iu, 1.2 ml multidose pen.....	344.52	1	✓ Intron-A
Inj 60 m iu, 1.2 ml multidose pen.....	689.04	1	✓ Intron-A

PEGYLATED INTERFERON ALFA-2A – Special Authority see [SA1400 below](#) – Retail pharmacy

See prescribing guideline [on the previous page](#)

Inj 180 mcg prefilled syringe.....	500.00	4	✓ Pegasys
Inj 135 mcg prefilled syringe x 4 with ribavirin tab 200 mg x 168.....	1,975.00	1 OP	✓ Pegasys RBV Combination Pack
Inj 180 mcg prefilled syringe x 4 with ribavirin tab 200 mg x 112.....	1,159.84	1 OP	✓ Pegasys RBV Combination Pack
Inj 180 mcg prefilled syringe x 4 with ribavirin tab 200 mg x 168.....	1,290.00	1 OP	✓ Pegasys RBV Combination Pack

(Pegasys RBV Combination Pack Inj 135 mcg prefilled syringe x 4 with ribavirin tab 200 mg x 168 to be delisted 1 December 2018)

(Pegasys RBV Combination Pack Inj 180 mcg prefilled syringe x 4 with ribavirin tab 200 mg x 112 to be delisted 1 December 2018)

(Pegasys RBV Combination Pack Inj 180 mcg prefilled syringe x 4 with ribavirin tab 200 mg x 168 to be delisted 1 December 2018)

➡SA1400 Special Authority for Subsidy

Initial application — (chronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV or genotype 2 or 3 post liver transplant) from any specialist. Approvals valid for 18 months for applications meeting the following criteria:

continued...

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
--	---	------------------------------	-------------------------------------

continued...

Both:

- 1 Any of the following:
 - 1.1 Patient has chronic hepatitis C, genotype 1, 4, 5 or 6 infection; or
 - 1.2 Patient has chronic hepatitis C and is co-infected with HIV; or
 - 1.3 Patient has chronic hepatitis C genotype 2 or 3 and has received a liver transplant; and
- 2 Maximum of 48 weeks therapy.

Notes:

- Consider stopping treatment if there is absence of a virological response (defined as at least a 2-log reduction in viral load) following 12 weeks of treatment since this is predictive of treatment failure.
- Consider reducing treatment to 24 weeks if serum HCV RNA level at Week 4 is undetectable by sensitive PCR assay (less than 50IU/ml) AND Baseline serum HCV RNA is less than 400,000IU/ml

Renewal — (Chronic hepatitis C - genotype 1 infection) only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 18 months for applications meeting the following criteria:

All of the following:

- 1 Patient has chronic hepatitis C, genotype 1; and
- 2 Patient has had previous treatment with pegylated interferon and ribavirin; and
- 3 Either:
 - 3.1 Patient has responder relapsed; or
 - 3.2 Patient was a partial responder; and
- 4 Patient is to be treated in combination with boceprevir; and
- 5 Maximum of 48 weeks therapy.

Initial application — (Chronic Hepatitis C - genotype 1 infection treatment more than 4 years prior) only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 18 months for applications meeting the following criteria:

All of the following:

- 1 Patient has chronic hepatitis C, genotype 1; and
- 2 Patient has had previous treatment with pegylated interferon and ribavirin; and
- 3 Any of the following:
 - 3.1 Patient has responder relapsed; or
 - 3.2 Patient was a partial responder; or
 - 3.3 Patient received interferon treatment prior to 2004; and
- 4 Patient is to be treated in combination with boceprevir; and
- 5 Maximum of 48 weeks therapy.

Initial application — (chronic hepatitis C - genotype 2 or 3 infection without co-infection with HIV) from any specialist.

Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 Patient has chronic hepatitis C, genotype 2 or 3 infection; and
- 2 Maximum of 6 months therapy.

Initial application — (Hepatitis B) only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 18 months for applications meeting the following criteria:

All of the following:

- 1 Patient has confirmed Hepatitis B infection (HBsAg positive for more than 6 months); and
- 2 Patient is Hepatitis B treatment-naïve; and
- 3 ALT > 2 times Upper Limit of Normal; and
- 4 HBV DNA < 10 log₁₀ IU/ml; and
- 5 Either:
 - 5.1 HBeAg positive; or

continued...

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

- 5.2 serum HBV DNA greater than or equal to 2,000 units/ml and significant fibrosis (Metavir Stage F2 or greater or moderate fibrosis); and
- 6 Compensated liver disease; and
- 7 No continuing alcohol abuse or intravenous drug use; and
- 8 Not co-infected with HCV, HIV or HDV; and
- 9 Neither ALT nor AST > 10 times upper limit of normal; and
- 10 No history of hypersensitivity or contraindications to pegylated interferon; and
- 11 Maximum of 48 weeks therapy.

Notes:

- Approved dose is 180 mcg once weekly.
- The recommended dose of Pegylated Interferon alfa-2a is 180 mcg once weekly.
- In patients with renal insufficiency (calculated creatinine clearance less than 50ml/min), Pegylated Interferon-alfa 2a dose should be reduced to 135 mcg once weekly.
- In patients with neutropaenia and thrombocytopaenia, dose should be reduced in accordance with the datasheet guidelines.
- Pegylated Interferon-alfa 2a is not approved for use in children.

Urinary Tract Infections

HEXAMINE HIPPURATE

* Tab 1 g	18.40 (40.01)	100		Hiprex
-----------------	------------------	-----	--	--------

NITROFURANTOIN

* Tab 50 mg	22.20	100	✓	Nifuran
* Tab 100 mg	37.50	100	✓	Nifuran

NORFLOXACIN

Tab 400 mg – Subsidy by endorsement.....	135.00	100	✓	Arrow-Norfloxacin
--	--------	-----	---	-------------------

Only if prescribed for a patient with an uncomplicated urinary tract infection that is unresponsive to a first line agent or with proven resistance to first line agents and the prescription is endorsed accordingly.

MUSCULOSKELETAL SYSTEM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
Anticholinesterases				
NEOSTIGMINE METILSULFATE				
Inj 2.5 mg per ml, 1 ml ampoule	98.00	50	✓	<u>AstraZeneca</u>
PYRIDOSTIGMINE BROMIDE				
▲ Tab 60 mg	42.79	100	✓	<u>Mestinon</u>
Non-Steroidal Anti-Inflammatory Drugs				
DICLOFENAC SODIUM				
* Tab EC 25 mg	1.23	50	✓	<u>Diclofenac Sandoz</u>
* Tab 50 mg dispersible	1.50	20	✓	<u>Voltaren D</u>
* Tab EC 50 mg	1.23	50	✓	<u>Diclofenac Sandoz</u>
* Tab long-acting 75 mg	22.80	500	✓	<u>Apo-Diclo SR</u>
* Tab long-acting 100 mg	25.15	500	✓	<u>Apo-Diclo SR</u>
* Inj 25 mg per ml, 3 ml ampoule – Up to 5 inj available on a PSO	13.20	5	✓	<u>Voltaren</u>
* Suppos 12.5 mg	2.04	10	✓	<u>Voltaren</u>
* Suppos 25 mg	2.44	10	✓	<u>Voltaren</u>
* Suppos 50 mg – Up to 10 supp available on a PSO	4.22	10	✓	<u>Voltaren</u>
* Suppos 100 mg	7.00	10	✓	<u>Voltaren</u>
IBUPROFEN				
* Tab 200 mg	11.71	1,000	✓	<u>Relieve</u>
* Tab long-acting 800 mg	7.99	30	✓	<u>Brufen SR</u>
* Oral liq 20 mg per ml	2.39	200 ml	✓	<u>Fenpaed</u>
KETOPROFEN				
* Cap long-acting 200 mg	12.07	28	✓	<u>Oruvail SR</u>
MEFENAMIC ACID				
* Cap 250 mg	1.25	50		
	(9.16)			Ponstan
	0.50	20		
	(5.60)			Ponstan
NAPROXEN				
* Tab 250 mg	32.69	500	✓	<u>Noflam 250</u>
Noflam 250 to be Sole Supply on 1 January 2019				
* Tab 500 mg	22.19	250	✓	<u>Noflam 500</u>
Noflam 500 to be Sole Supply on 1 January 2019				
* Tab long-acting 750 mg	6.16	28	✓	<u>Naprosyn SR 750</u>
* Tab long-acting 1 g	8.21	28	✓	<u>Naprosyn SR 1000</u>
SULINDAC				
* Tab 100 mg	8.55	50	✓	<u>Aclin</u>
* Tab 200 mg	15.10	50	✓	<u>Aclin</u>
TENOXICAM				
* Tab 20 mg	10.95	100	✓	<u>Tilcotil</u>
* Inj 20 mg vial	9.95	1	✓	<u>AFT</u>
NSAIDs Other				
CELECOXIB				
Cap 100 mg	3.63	60	✓	<u>Celecoxib Pfizer</u>
Cap 200 mg	2.30	30	✓	<u>Celecoxib Pfizer</u>

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
---	----------------------------	-------------------------------------

Topical Products for Joint and Muscular Pain

CAPSAICIN

Crm 0.025% – Special Authority see [SA1289 below](#) – Retail

pharmacy.....	6.95	25 g OP	✓ Zostrix
	9.95	45 g OP	✓ Zostrix

►SA1289 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid without further renewal unless notified where the patient has osteoarthritis that is not responsive to paracetamol and oral non-steroidal anti-inflammatories are contraindicated.

Antirheumatoid Agents

HYDROXYCHLOROQUINE

* Tab 200 mg	7.98	100	✓ Plaquenil
--------------------	------	-----	--------------------

LEFLUNOMIDE

Tab 10 mg	2.90	30	✓ Apo-Leflunomide
Tab 20 mg	2.90	30	✓ Apo-Leflunomide

PENICILLAMINE

Tab 125 mg	67.23	100	✓ D-Penamine
Tab 250 mg	110.12	100	✓ D-Penamine

SODIUM AUROTHIOMALATE

Inj 10 mg in 0.5 ml ampoule	76.87	10	✓ Myocrisin
Inj 20 mg in 0.5 ml ampoule	113.17	10	✓ Myocrisin
Inj 50 mg in 0.5 ml ampoule	217.23	10	✓ Myocrisin

Drugs Affecting Bone Metabolism

Alendronate for Osteoporosis

►SA1039 Special Authority for Subsidy

Initial application — (Underlying cause - Osteoporosis) from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Any of the following:

- 1 History of one significant osteoporotic fracture demonstrated radiologically and documented bone mineral density (BMD) greater than or equal to 2.5 standard deviations below the mean normal value in young adults (i.e. T-Score less than or equal to -2.5) (see Note); or
- 2 History of one significant osteoporotic fracture demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of major logistical, technical or pathophysiological reasons. It is unlikely that this provision would apply to many patients under 75 years of age; or
- 3 History of two significant osteoporotic fractures demonstrated radiologically; or
- 4 Documented T-Score less than or equal to -3.0 (see Note); or
- 5 A 10-year risk of hip fracture greater than or equal to 3%, calculated using a published risk assessment algorithm (e.g. FRAX or Garvan) which incorporates BMD measurements (see Note); or
- 6 Patient has had a Special Authority approval for zoledronic acid (Underlying cause - Osteoporosis) or raloxifene.

Initial application — (Underlying cause - glucocorticosteroid therapy) from any relevant practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Both:

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

- 1 The patient is receiving systemic glucocorticosteroid therapy (greater than or equal to 5 mg per day prednisone equivalents) and has already received or is expected to receive therapy for at least three months; and
- 2 Any of the following:
 - 2.1 The patient has documented BMD greater than or equal to 1.5 standard deviations below the mean normal value in young adults (i.e. T-Score less than or equal to -1.5) (see Note); or
 - 2.2 The patient has a history of one significant osteoporotic fracture demonstrated radiologically; or
 - 2.3 The patient has had a Special Authority approval for zoledronic acid (Underlying cause - glucocorticosteroid therapy) or raloxifene.

Renewal — (Underlying cause was, and remains, glucocorticosteroid therapy) from any relevant practitioner. Approvals valid for 1 year where the patient is continuing systemic glucocorticosteroid therapy (greater than or equal to 5 mg per day prednisone equivalents).

Renewal — (Underlying cause was glucocorticosteroid therapy but patient now meets the 'Underlying cause - osteoporosis' criteria) from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Any of the following:

- 1 History of one significant osteoporotic fracture demonstrated radiologically and documented bone mineral density (BMD) greater than or equal to 2.5 standard deviations below the mean normal value in young adults (i.e. T-Score less than or equal to -2.5) (see Note); or
- 2 History of one significant osteoporotic fracture demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of major logistical, technical or pathophysiological reasons. It is unlikely that this provision would apply to many patients under 75 years of age; or
- 3 History of two significant osteoporotic fractures demonstrated radiologically; or
- 4 Documented T-Score less than or equal to -3.0 (see Note); or
- 5 A 10-year risk of hip fracture greater than or equal to 3%, calculated using a published risk assessment algorithm (e.g. FRAX or Garvan) which incorporates BMD measurements (see Note); or
- 6 Patient has had a Special Authority approval for zoledronic acid (Underlying cause was glucocorticosteroid therapy but patient now meets the 'Underlying cause - Osteoporosis' criteria) or raloxifene.

Notes:

- a) BMD (including BMD used to derive T-Score) must be measured using dual-energy x-ray absorptiometry (DXA). Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable.
- b) Evidence suggests patients aged 75 years and over who have a history of significant osteoporotic fracture demonstrated radiologically are very likely to have a T-Score less than or equal to -2.5 and, therefore, do not require BMD measurement for treatment with bisphosphonates.
- c) Osteoporotic fractures are the incident events for severe (established) osteoporosis, and can be defined using the WHO definitions of osteoporosis and fragility fracture. The WHO defines severe (established) osteoporosis as a T-score below -2.5 with one or more associated fragility fractures. Fragility fractures are fractures that occur as a result of mechanical forces that would not ordinarily cause fracture (minimal trauma). The WHO has quantified this as forces equivalent to a fall from a standing height or less.
- d) In line with the Australian guidelines for funding alendronate, a vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

ALENDRONATE SODIUM – Special Authority see [SA1039 on the previous page](#) – Retail pharmacy

* Tab 70 mg	4.82	4	✓ Fosamax
-------------------	------	---	-----------

ALENDRONATE SODIUM WITH COLECALCIFEROL – Special Authority see [SA1039 on the previous page](#) – Retail pharmacy

* Tab 70 mg with colecalciferol 5,600 iu	4.82	4	✓ Fosamax Plus
--	------	---	----------------

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

Alendronate for Paget's Disease

►SA0949 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Paget's disease; and
- 2 Any of the following:
 - 2.1 Bone or articular pain; or
 - 2.2 Bone deformity; or
 - 2.3 Bone, articular or neurological complications; or
 - 2.4 Asymptomatic disease, but risk of complications due to site (base of skull, spine, long bones of lower limbs); or
 - 2.5 Preparation for orthopaedic surgery.

Renewal from any relevant practitioner. Approvals valid for 6 months where the treatment remains appropriate and the patient is benefiting from treatment.

ALENDRONATE SODIUM – Special Authority see SA0949 above – Retail pharmacy

* Tab 40 mg	133.00	30	✓ Fosamax
-------------------	--------	----	-----------

Other Treatments

DENOSUMAB – Special Authority see SA1730 below – Retail pharmacy

Inj 60 mg prefilled syringe.....	326.00	1	✓ Prolia
----------------------------------	--------	---	----------

►SA1730 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 The patient has severe, established osteoporosis; and
- 2 Either:
 - 2.1 The patient is female and postmenopausal; or
 - 2.2 The patient is male or non-binary; and
- 3 Any of the following:
 - 3.1 History of one significant osteoporotic fracture demonstrated radiologically and documented bone mineral density (BMD) greater than or equal to 2.5 standard deviations below the mean normal value in young adults (i.e. T-Score less than or equal to -2.5) (see Note); or
 - 3.2 History of one significant osteoporotic fracture demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of major logistical, technical or pathophysiological reasons; or
 - 3.3 History of two significant osteoporotic fractures demonstrated radiologically; or
 - 3.4 Documented T-Score less than or equal to -3.0 (see Note); or
 - 3.5 A 10-year risk of hip fracture greater than or equal to 3%, calculated using a published risk assessment algorithm (e.g. FRAX or Garvan) which incorporates BMD measurements (see Note); or
 - 3.6 Patient has had a Special Authority approval for alendronate (Underlying cause - Osteoporosis) or raloxifene; and
- 4 Zoledronic acid is contraindicated because the patient's creatinine clearance is less than 35 mL/min; and
- 5 The patient has experienced at least one symptomatic new fracture after at least 12 months' continuous therapy with a funded antiresorptive agent at adequate doses (see Notes); and
- 6 The patient must not receive concomitant treatment with any other funded antiresorptive agent for this condition or teriparatide.

Notes:

- a) BMD (including BMD used to derive T-Score) must be measured using dual-energy x-ray absorptiometry (DXA).

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

- Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable
- Evidence suggests that patients aged 75 years and over who have a history of significant osteoporotic fracture demonstrated radiologically are very likely to have a T-Score less than or equal to -2.5 and, therefore, do not require BMD measurement for treatment with denosumab
 - Osteoporotic fractures are the incident events for severe (established) osteoporosis and can be defined using the WHO definitions of osteoporosis and fragility fracture. The WHO defines severe (established) osteoporosis as a T-score below -2.5 with one or more associated fragility fractures. Fragility fractures are fractures that occur as a result of mechanical forces that would not ordinarily cause fracture (minimal trauma). The WHO has quantified this as forces equivalent to a fall from a standing height or less
 - A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body
 - Antiresorptive agents and their adequate doses for the purposes of this Special Authority are defined as: risedronate sodium tab 35 mg once weekly; alendronate sodium tab 70 mg or tab 70 mg with cholecalciferol 5,600 iu once weekly; raloxifene hydrochloride tab 60 mg once daily. If an intolerance of a severity necessitating permanent treatment withdrawal develops during the use of one antiresorptive agent, an alternate antiresorptive agent must be trialled so that the patient achieves the minimum requirement of 12 months' continuous therapy

ETIDRONATE DISODIUM – See prescribing guideline [below](#)

* Tab 200 mg	13.50	100	✓	Arrow-Etidronate
--------------------	-------	-----	---	------------------

(Arrow-Etidronate Tab 200 mg to be delisted 1 January 2019)

Prescribing Guidelines

Etidronate for osteoporosis should be prescribed for 14 days (400 mg in the morning) and repeated every three months. It should not be taken at the same time of the day as any calcium supplementation (minimum dose – 500 mg per day of elemental calcium). Etidronate should be taken at least 2 hours before or after any food or fluid, except water.

PAMIDRONATE DISODIUM

Inj 3 mg per ml, 10 ml vial.....	5.98	1	✓	Pamisol
Inj 6 mg per ml, 10 ml vial.....	15.02	1	✓	Pamisol
Inj 9 mg per ml, 10 ml vial.....	17.05	1	✓	Pamisol

RALOXIFENE HYDROCHLORIDE – Special Authority see [SA1138 below](#) – Retail pharmacy

* Tab 60 mg	53.76	28	✓	Evista
-------------------	-------	----	---	--------

►SA1138 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Any of the following:

- History of one significant osteoporotic fracture demonstrated radiologically and documented bone mineral density (BMD) greater than or equal to 2.5 standard deviations below the mean normal value in young adults (i.e. T-Score less than or equal to -2.5) (see Notes); or
- History of one significant osteoporotic fracture demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of major logistical, technical or pathophysiological reasons. It is unlikely that this provision would apply to many patients under 75 years of age; or
- History of two significant osteoporotic fractures demonstrated radiologically; or
- Documented T-Score less than or equal to -3.0 (see Notes); or
- A 10-year risk of hip fracture greater than or equal to 3%, calculated using a published risk assessment algorithm (e.g. FRAX or Garvan) which incorporates BMD measurements (see Notes); or
- Patient has had a prior Special Authority approval for zoledronic acid (Underlying cause - Osteoporosis) or alendronate (Underlying cause - Osteoporosis).

Notes:

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
	✓	

continued...

- BMD (including BMD used to derive T-Score) must be measured using dual-energy x-ray absorptiometry (DXA). Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable.
- Evidence suggests that patients aged 75 years and over who have a history of significant osteoporotic fracture demonstrated radiologically are very likely to have a T-Score less than or equal to -2.5 and, therefore, do not require BMD measurement for raloxifene funding.
- Osteoporotic fractures are the incident events for severe (established) osteoporosis, and can be defined using the WHO definitions of osteoporosis and fragility fracture. The WHO defines severe (established) osteoporosis as a T-score below -2.5 with one or more associated fragility fractures. Fragility fractures are fractures that occur as a result of mechanical forces that would not ordinarily cause fracture (minimal trauma). The WHO has quantified this as forces equivalent to a fall from a standing height or less.
- A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

RISEDRONATE SODIUM

Tab 35 mg3.80 4 ✓ **Risedronate Sandoz**

TERIPARATIDE – Special Authority see [SA1139 below](#) – Retail pharmacy

Inj 250 mcg per ml, 2.4 ml490.00 1 ✓ **Forteo**

► [SA1139](#) Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 18 months for applications meeting the following criteria:

All of the following:

- The patient has severe, established osteoporosis; and
- The patient has a documented T-score less than or equal to -3.0 (see Notes); and
- The patient has had two or more fractures due to minimal trauma; and
- The patient has experienced at least one symptomatic new fracture after at least 12 months' continuous therapy with a funded antiresorptive agent at adequate doses (see Notes).

Notes:

- The bone mineral density (BMD) measurement used to derive the T-score must be made using dual-energy x-ray absorptiometry (DXA). Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable
- Antiresorptive agents and their adequate doses for the purposes of this Special Authority are defined as: alendronate sodium tab 70 mg or tab 70 mg with colecalciferol 5,600 iu once weekly; raloxifene hydrochloride tab 60 mg once daily; zoledronic acid 5 mg per year. If an intolerance of a severity necessitating permanent treatment withdrawal develops during the use of one antiresorptive agent, an alternate antiresorptive agent must be trialled so that the patient achieves the minimum requirement of 12 months' continuous therapy.
- A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.
- A maximum of 18 months of treatment (18 cartridges) will be subsidised.

ZOLEDRONIC ACID

Inj 0.05 mg per ml, 100 ml, vial – Special Authority see

[SA1187 below](#) – Retail pharmacy600.00 100 ml OP ✓ **Aclasta**

► [SA1187](#) Special Authority for Subsidy

Initial application — (Paget's disease) from any relevant practitioner. Approvals valid for 1 year for applications meeting the following criteria:

All of the following:

- Paget's disease; and
- Any of the following:

continued...

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

- 2.1 Bone or articular pain; or
- 2.2 Bone deformity; or
- 2.3 Bone, articular or neurological complications; or
- 2.4 Asymptomatic disease, but risk of complications; or
- 2.5 Preparation for orthopaedic surgery; and

3 The patient will not be prescribed more than 5 mg of zoledronic acid in the 12-month approval period.

Initial application — (Underlying cause - Osteoporosis) from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

1 Any of the following:

- 1.1 History of one significant osteoporotic fracture demonstrated radiologically and documented bone mineral density (BMD) greater than or equal to 2.5 standard deviations below the mean normal value in young adults (i.e. T-Score less than or equal to -2.5) (see Note); or
- 1.2 History of one significant osteoporotic fracture demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of major logistical, technical or pathophysiological reasons. It is unlikely that this provision would apply to many patients under 75 years of age; or
- 1.3 History of two significant osteoporotic fractures demonstrated radiologically; or
- 1.4 Documented T-Score less than or equal to -3.0 (see Note); or
- 1.5 A 10-year risk of hip fracture greater than or equal to 3%, calculated using a published risk assessment algorithm (e.g. FRAX or Garvan) which incorporates BMD measurements (see Note); or
- 1.6 Patient has had a Special Authority approval for alendronate (Underlying cause - Osteoporosis) or raloxifene; and

2 The patient will not be prescribed more than 5 mg of zoledronic acid in a 12-month period.

Initial application — (Underlying cause - glucocorticosteroid therapy) from any relevant practitioner. Approvals valid for 1 year for applications meeting the following criteria:

All of the following:

- 1 The patient is receiving systemic glucocorticosteroid therapy (greater than or equal to 5 mg per day prednisone equivalents) and has already received or is expected to receive therapy for at least three months; and
- 2 Any of the following:
 - 2.1 The patient has documented BMD greater than or equal to 1.5 standard deviations below the mean normal value in young adults (i.e. T-Score less than or equal to -1.5) (see Note); or
 - 2.2 The patient has a history of one significant osteoporotic fracture demonstrated radiologically; or
 - 2.3 The patient has had a Special Authority approval for alendronate (Underlying cause - glucocorticosteroid therapy) or raloxifene; and
- 3 The patient will not be prescribed more than 5 mg of zoledronic acid in the 12-month approval period.

Renewal — (Paget's disease) from any relevant practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Both:

1 Any of the following:

- 1.1 The patient has relapsed (based on increases in serum alkaline phosphatase); or
- 1.2 The patient's serum alkaline phosphatase has not normalised following previous treatment with zoledronic acid; or
- 1.3 Symptomatic disease (prescriber determined); and

2 The patient will not be prescribed more than 5 mg of zoledronic acid in the 12-month approval period.

The patient must not have had more than 1 prior approval in the last 12 months.

Renewal — (Underlying cause was, and remains, glucocorticosteroid therapy) from any relevant practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Both:

- 1 The patient is continuing systemic glucocorticosteroid therapy (greater than or equal to 5 mg per day prednisone

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

equivalents); and

2 The patient will not be prescribed more than 5 mg of zoledronic acid in the 12-month approval period.

The patient must not have had more than 1 prior approval in the last 12 months.

Renewal — (Underlying cause was glucocorticosteroid therapy but patient now meets the 'Underlying cause - osteoporosis' criteria) from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

1 Any of the following:

- 1.1 History of one significant osteoporotic fracture demonstrated radiologically and documented bone mineral density (BMD) greater than or equal to 2.5 standard deviations below the mean normal value in young adults (i.e. T-Score less than or equal to -2.5) (see Note); or
- 1.2 History of one significant osteoporotic fracture demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of major logistical, technical or pathophysiological reasons. It is unlikely that this provision would apply to many patients under 75 years of age; or
- 1.3 History of two significant osteoporotic fractures demonstrated radiologically; or
- 1.4 Documented T-Score less than or equal to -3.0 (see Note); or
- 1.5 A 10-year risk of hip fracture greater than or equal to 3%, calculated using a published risk assessment algorithm (e.g. FRAX or Garvan) which incorporates BMD measurements (see Note); or
- 1.6 Patient has had a Special Authority approval for alendronate (Underlying cause was glucocorticosteroid therapy but patient now meets the 'Underlying cause - Osteoporosis' criteria) or raloxifene; and

2 The patient will not be prescribed more than 5 mg of zoledronic acid in a 12-month period.

Notes:

- a) BMD (including BMD used to derive T-Score) must be measured using dual-energy x-ray absorptiometry (DXA). Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable.
- b) Evidence suggests that patients aged 75 years and over who have a history of significant osteoporotic fracture demonstrated radiologically are very likely to have a T-Score less than or equal to -2.5 and, therefore, do not require BMD measurement for treatment with bisphosphonates.
- c) Osteoporotic fractures are the incident events for severe (established) osteoporosis and can be defined using the WHO definitions of osteoporosis and fragility fracture. The WHO defines severe (established) osteoporosis as a T-score below -2.5 with one or more associated fragility fractures. Fragility fractures are fractures that occur as a result of mechanical forces that would not ordinarily cause fracture (minimal trauma). The WHO has quantified this as forces equivalent to a fall from a standing height or less.
- d) A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

Hyperuricaemia and Antigout

ALLOPURINOL

* Tab 100 mg	4.54	500	✓ DP-Allopurinol
* Tab 300 mg	10.35	500	✓ DP-Allopurinol

BENZBROMARONE – Special Authority see [SA1537 below](#) – Retail pharmacy

Tab 100 mg	45.00	100	✓ Benzbromaron AL
			100 <small>\$29</small>

►SA1537 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

continued...

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

- 1 Patient has been diagnosed with gout; and
- 2 Any of the following:
 - 2.1 The patient has a serum urate level greater than 0.36 mmol/l despite treatment with allopurinol at doses of at least 600 mg/day and addition of probenecid at doses of up to 2 g per day or maximum tolerated dose; or
 - 2.2 The patient has experienced intolerable side effects from allopurinol such that treatment discontinuation is required and serum urate remains greater than 0.36 mmol/l despite use of probenecid at doses of up to 2 g per day or maximum tolerated dose; or
 - 2.3 Both:
 - 2.3.1 The patient has renal impairment such that probenecid is contraindicated or likely to be ineffective and serum urate remains greater than 0.36 mmol/l despite optimal treatment with allopurinol (see Notes); and
 - 2.3.2 The patient has a rate of creatinine clearance greater than or equal to 20 ml/min; or
 - 2.4 All of the following:
 - 2.4.1 The patient is taking azathioprine and requires urate-lowering therapy; and
 - 2.4.2 Allopurinol is contraindicated; and
 - 2.4.3 Appropriate doses of probenecid are ineffective or probenecid cannot be used due to reduced renal function; and
- 3 The patient is receiving monthly liver function tests.

Renewal from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefitting from the treatment; and
- 2 There is no evidence of liver toxicity and patient is continuing to receive regular (at least every three months) liver function tests.

Notes: Benzbromarone has been associated with potentially fatal hepatotoxicity.

In chronic renal insufficiency, particularly when the glomerular filtration rate is 30 ml/minute or less, probenecid may not be effective. Optimal treatment with allopurinol in patients with renal impairment is defined as treatment to the creatinine clearance-adjusted dose of allopurinol then, if serum urate remains greater than 0.36 mmol/l, a gradual increase of the dose of allopurinol to 600 mg or the maximum tolerated dose.

The New Zealand Rheumatology Association has developed information for prescribers which can be accessed from its website at www.rheumatology.org.nz/home/resources-2/

COLCHICINE

* Tab 500 mcg.....	9.58	100	✓ Colgout
Colgout to be Sole Supply on 1 February 2019			

FEBUXOSTAT – Special Authority see [SA1538 below](#) – Retail pharmacy

Tab 80 mg	39.50	28	✓ Adenuric
Tab 120 mg	39.50	28	✓ Adenuric

►SA1538 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Patient has been diagnosed with gout; and
- 2 Any of the following:
 - 2.1 The patient has a serum urate level greater than 0.36 mmol/l despite treatment with allopurinol at doses of at least 600 mg/day and addition of probenecid at doses of up to 2 g per day or maximum tolerated dose; or
 - 2.2 The patient has experienced intolerable side effects from allopurinol such that treatment discontinuation is required and serum urate remains greater than 0.36 mmol/l despite use of probenecid at doses of up to 2 g per day or maximum tolerated dose; or
 - 2.3 The patient has renal impairment such that probenecid is contraindicated or likely to be ineffective and serum urate

continued...

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
--	---	----------------------------	-------------------------------------

continued...

remains greater than 0.36 mmol/l despite optimal treatment with allopurinol (see Note).

Renewal from any relevant practitioner. Approvals valid for 2 years where the treatment remains appropriate and the patient is benefitting from treatment.

Note: In chronic renal insufficiency, particularly when the glomerular filtration rate is 30 ml/minute or less, probenecid may not be effective. The efficacy and safety of febuxostat have not been fully evaluated in patients with severe renal impairment (creatinine clearance less than 30 ml/minute). No dosage adjustment of febuxostat is necessary in patients with mild or moderate renal impairment. Optimal treatment with allopurinol in patients with renal impairment is defined as treatment to the creatinine clearance-adjusted dose of allopurinol then, if serum urate remains greater than 0.36 mmol/l, a gradual increase of the dose of allopurinol to 600 mg or the maximum tolerated dose.

PROBENECID

* Tab 500 mg	55.00	100	✓ Probenecid-AFT
--------------------	-------	-----	------------------

Muscle Relaxants

BACLOFEN

* Tab 10 mg	4.20	100	✓ <u>Pacifen</u>
Inj 0.05 mg per ml, 1 ml ampoule – Subsidy by endorsement.....	11.55	1	✓ <u>Lioresal Intrathecal</u>
Subsidised only for use in a programmable pump in patients where oral antispastic agents have been ineffective or have caused intolerable side effects and the prescription is endorsed accordingly.			
Inj 2 mg per ml, 5 ml ampoule – Subsidy by endorsement.....	209.29	1	✓ <u>Lioresal Intrathecal</u>
Subsidised only for use in a programmable pump in patients where oral antispastic agents have been ineffective or have caused intolerable side effects and the prescription is endorsed accordingly.			

DANTROLENE

Cap 25 mg	65.00	100	✓ <u>Dantrium</u>
Cap 50 mg	77.00	100	✓ <u>Dantrium S29</u> <small>S29</small>
			✓ <u>Dantrium</u>

ORPHENADRINE CITRATE

Tab 100 mg	18.54	100	✓ <u>Norflex</u>
------------------	-------	-----	------------------

Agents for Parkinsonism and Related Disorders

Dopamine Agonists and Related Agents

AMANTADINE HYDROCHLORIDE

▲ Cap 100 mg 38.24 60 ✓ **Symmetrel**

APOMORPHINE HYDROCHLORIDE

▲ Inj 10 mg per ml, 2 ml ampoule 119.00 5 ✓ **Movapo**

BROMOCRIPTINE MESYLATE

* Tab 2.5 mg 32.08 100 ✓ **Apo-Bromocriptine**

ENTACAPONE

▲ Tab 200 mg 22.00 100 ✓ **Entapone**

LEVODOPA WITH BENSERAZIDE

* Tab dispersible 50 mg with benserazide 12.5 mg 13.25 100 ✓ **Madopar Rapid**

* Cap 50 mg with benserazide 12.5 mg 13.75 100 ✓ **Madopar 62.5**

* Cap 100 mg with benserazide 25 mg 15.80 100 ✓ **Madopar 125**

* Cap long-acting 100 mg with benserazide 25 mg 22.85 100 ✓ **Madopar HBS**

* Cap 200 mg with benserazide 50 mg 26.25 100 ✓ **Madopar 250**

LEVODOPA WITH CARBIDOPA

* Tab 100 mg with carbidopa 25 mg 17.97 100 ✓ **Kinson**

* Tab long-acting 200 mg with carbidopa 50 mg 37.15 100 ✓ **Sinemet**

* Tab 250 mg with carbidopa 25 mg 32.67 100 ✓ **Sinemet CR**

(Kinson Tab 100 mg with carbidopa 25 mg to be delisted 1 June 2019)

PRAMIPEXOLE HYDROCHLORIDE

▲ Tab 0.25 mg 7.20 100 ✓ **Ramipex**

▲ Tab 1 mg 24.39 100 ✓ **Ramipex**

ROPINIROLE HYDROCHLORIDE

▲ Tab 0.25 mg 2.78 100 ✓ **Apo-Ropinirole**

▲ Tab 1 mg 5.00 100 ✓ **Apo-Ropinirole**

▲ Tab 2 mg 7.72 100 ✓ **Apo-Ropinirole**

▲ Tab 5 mg 16.51 100 ✓ **Apo-Ropinirole**

SELEGILINE HYDROCHLORIDE

* Tab 5 mg 22.00 100 ✓ **Apo-Selegiline**
S29 S29

TOLCAPONE

▲ Tab 100 mg 132.50 100 ✓ **Tasmar**

Anticholinergics

BENZATROPINE MESYLATE

Tab 2 mg 7.99 60 ✓ **Benztrap**

Inj 1 mg per ml, 2 ml 95.00 5 ✓ **Cogentin**

190.00 10 ✓ **Omega**

a) Up to 10 inj available on a PSO

b) Only on a PSO

PROCYCLIDINE HYDROCHLORIDE

Tab 5 mg 7.40 100 ✓ **Kemadrin**

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
---	----------------------------	-------------------------------------

Agents for Essential Tremor, Chorea and Related Disorders

RILUZOLE – Special Authority see [SA1403 below](#) – Retail pharmacy

Wastage claimable

Tab 50 mg	130.00	56	✓ Rilutek
-----------------	--------	----	------------------

»SA1403 Special Authority for Subsidy

Initial application only from a neurologist or respiratory specialist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 The patient has amyotrophic lateral sclerosis with disease duration of 5 years or less; and
- 2 The patient has at least 60 percent of predicted forced vital capacity within 2 months prior to the initial application; and
- 3 The patient has not undergone a tracheostomy; and
- 4 The patient has not experienced respiratory failure; and
- 5 Any of the following:
 - 5.1 The patient is ambulatory; or
 - 5.2 The patient is able to use upper limbs; or
 - 5.3 The patient is able to swallow.

Renewal from any relevant practitioner. Approvals valid for 18 months for applications meeting the following criteria:

All of the following:

- 1 The patient has not undergone a tracheostomy; and
- 2 The patient has not experienced respiratory failure; and
- 3 Any of the following:
 - 3.1 The patient is ambulatory; or
 - 3.2 The patient is able to use upper limbs; or
 - 3.3 The patient is able to swallow.

TETRABENAZINE

Tab 25 mg	91.10	112	✓ Motetis
-----------------	-------	-----	------------------

Anaesthetics

Local

LIDOCAINE [LIGNOCAINE]

Gel 2%, tube – Subsidy by endorsement	14.50	30 ml	✓ Xylocaine 2% Jelly
---	-------	-------	-----------------------------

a) Up to 150 ml available on a PSO

b) Subsidised only if prescribed for urethral or cervical administration and the prescription is endorsed accordingly.

Gel 2%, 10 ml urethral syringe – Subsidy by endorsement.....	81.50	10	✓ Pfizer
	160.00	25	✓ Cathejell

a) Up to 5 each available on a PSO

b) Subsidised only if prescribed for urethral or cervical administration and the prescription is endorsed accordingly.

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
LIDOCAINE [LIGNOCAINE] HYDROCHLORIDE				
Oral (gel) soln 2%.....	38.00	200 ml	✓	Mucosoothe
Inj 1%, 5 ml ampoule – Up to 25 inj available on a PSO.....	8.75	25	✓	Lidocaine-Clarix
	17.50	50		
	(35.00)			Xylocaine
Inj 2%, 5 ml ampoule – Up to 5 inj available on a PSO.....	6.75	25	✓	Lidocaine-Clarix
Inj 1%, 20 ml ampoule – Up to 5 inj available on a PSO.....	2.40	1	✓	Lidocaine-Clarix
	12.00	5		
	(20.00)			Xylocaine
Inj 1%, 20 ml vial – Up to 5 inj available on a PSO.....	12.00	5	✓	Lidocaine-Clarix
Inj 2%, 20 ml ampoule – Up to 5 inj available on a PSO.....	2.40	1	✓	Lidocaine-Clarix
Inj 2%, 20 ml vial – Up to 5 inj available on a PSO.....	12.00	5	✓	Lidocaine-Clarix
<i>(Lidocaine-Clarix Inj 1%, 20 ml ampoule to be delisted 1 February 2019)</i>				
<i>(Lidocaine-Clarix Inj 2%, 20 ml ampoule to be delisted 1 February 2019)</i>				
LIDOCAINE [LIGNOCAINE] WITH CHLORHEXIDINE				
Gel 2% with chlorhexidine 0.05%, 10 ml urethral syringes –				
Subsidy by endorsement.....	81.50	10	✓	Pfizer
a) Up to 5 each available on a PSO				
b) Subsidised only if prescribed for urethral or cervical administration and the prescription is endorsed accordingly.				

Topical Local Anaesthetics

►SA0906 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 2 years where the patient is a child with a chronic medical condition requiring frequent injections or venepuncture.

Renewal from any relevant practitioner. Approvals valid for 2 years where the treatment remains appropriate and the patient is benefiting from treatment.

LIDOCAINE [LIGNOCAINE] – Special Authority see [SA0906 above](#) – Retail pharmacy

Crm 4%.....	5.40	5 g OP	✓	LMX4
	27.00	30 g OP	✓	LMX4

LIDOCAINE [LIGNOCAINE] WITH PRILOCAINE – Special Authority see [SA0906 above](#) – Retail pharmacy

Crm 2.5% with prilocaine 2.5%.....	45.00	30 g OP	✓	EMLA
Crm 2.5% with prilocaine 2.5% (5 g tubes)	45.00	5	✓	EMLA

Analgesics

For Anti-inflammatory NSAIDs refer to MUSCULOSKELETAL, [page 112](#)

Non-opioid Analgesics

For aspirin & chloroform application refer Standard Formulae, [page 215](#)

ASPIRIN

* Tab dispersible 300 mg – Up to 30 tab available on a PSO.....	3.90	100	✓	Ethics Aspirin
---	------	-----	---	-----------------------

CAPSAICIN – Subsidy by endorsement

Subsidised only if prescribed for post-herpetic neuralgia or diabetic peripheral neuropathy and the prescription is endorsed accordingly.

Crm 0.075%.....	12.50	45 g OP	✓	Zostrix HP
-----------------	-------	---------	---	-------------------

NEFOPAM HYDROCHLORIDE

Tab 30 mg	23.40	90	✓	Acupan
-----------------	-------	----	---	---------------

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
PARACETAMOL				
* Tab 500 mg - blister pack – Up to 30 tab available on a PSO.....	7.12	1,000	✓	Pharmacare
* Tab 500 mg - bottle pack.....	6.32	1,000	✓	Pharmacare
* Oral liq 120 mg per 5 ml.....	5.35	1,000 ml	✓	Paracare
a) Up to 200 ml available on a PSO				
b) Not in combination				
* Oral liq 250 mg per 5 ml.....	5.81	1,000 ml	✓	Paracare Double Strength
a) Up to 100 ml available on a PSO				
b) Not in combination				
* Suppos 125 mg.....	3.29	10	✓	Gacet
Gacet to be Sole Supply on 1 December 2018				
* Suppos 250 mg.....	3.79	10	✓	Gacet
Gacet to be Sole Supply on 1 December 2018				
* Suppos 500 mg.....	12.60	50	✓	Paracare
Opioid Analgesics				
CODEINE PHOSPHATE – Safety medicine; prescriber may determine dispensing frequency				
Tab 15 mg.....	5.75	100	✓	PSM
Tab 30 mg.....	6.80	100	✓	PSM
Tab 60 mg.....	13.50	100	✓	PSM
DIHYDROCODEINE TARTRATE				
Tab long-acting 60 mg.....	9.55	60	✓	DHC Continus
FENTANYL				
a) Only on a controlled drug form				
b) No patient co-payment payable				
c) Safety medicine; prescriber may determine dispensing frequency				
Inj 50 mcg per ml, 2 ml ampoule.....	3.56	10	✓	Boucher and Muir
Boucher and Muir to be Sole Supply on 1 December 2018				
Inj 50 mcg per ml, 10 ml ampoule.....	9.41	10	✓	Boucher and Muir
Boucher and Muir to be Sole Supply on 1 December 2018				
Patch 12.5 mcg per hour.....	2.95	5	✓	Fentanyl Sandoz
Patch 25 mcg per hour.....	3.66	5	✓	Fentanyl Sandoz
Patch 50 mcg per hour.....	6.65	5	✓	Fentanyl Sandoz
Patch 75 mcg per hour.....	9.25	5	✓	Fentanyl Sandoz
Patch 100 mcg per hour.....	11.40	5	✓	Fentanyl Sandoz
METHADONE HYDROCHLORIDE				
a) Only on a controlled drug form				
b) No patient co-payment payable				
c) Safety medicine; prescriber may determine dispensing frequency				
d) Extemporaneously compounded methadone will only be reimbursed at the rate of the cheapest form available (methadone powder, not methadone tablets).				
e) For methadone hydrochloride oral liquid refer Standard Formulae, page 215				
Tab 5 mg.....	1.85	10	✓	Methatabs
Oral liq 2 mg per ml.....	5.79	200 ml	✓	Biodone
Oral liq 5 mg per ml.....	5.79	200 ml	✓	Biodone Forte
Oral liq 10 mg per ml.....	6.79	200 ml	✓	Biodone Extra Forte
Inj 10 mg per ml, 1 ml.....	61.00	10	✓	AFT

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
MORPHINE HYDROCHLORIDE				
a) Only on a controlled drug form				
b) No patient co-payment payable				
c) Safety medicine; prescriber may determine dispensing frequency				
Oral liq 1 mg per ml 9.28	200 ml	✓	RA-Morph	
RA-Morph to be Sole Supply on 1 January 2019				
Oral liq 2 mg per ml 16.24	200 ml	✓	RA-Morph	
RA-Morph to be Sole Supply on 1 January 2019				
Oral liq 5 mg per ml 19.44	200 ml	✓	RA-Morph	
RA-Morph to be Sole Supply on 1 January 2019				
Oral liq 10 mg per ml 27.74	200 ml	✓	RA-Morph	
RA-Morph to be Sole Supply on 1 January 2019				
MORPHINE SULPHATE				
a) Only on a controlled drug form				
b) No patient co-payment payable				
c) Safety medicine; prescriber may determine dispensing frequency				
Tab immediate-release 10 mg 2.80	10	✓	Sevredol	
Tab long-acting 10 mg 1.93	10	✓	Arrow-Morphine LA	
Tab immediate-release 20 mg 5.52	10	✓	Sevredol	
Tab long-acting 30 mg 2.85	10	✓	Arrow-Morphine LA	
Tab long-acting 60 mg 5.60	10	✓	Arrow-Morphine LA	
Tab long-acting 100 mg 6.10	10	✓	Arrow-Morphine LA	
Cap long-acting 10 mg 1.70	10	✓	m-Eslon	
Cap long-acting 30 mg 2.50	10	✓	m-Eslon	
Cap long-acting 60 mg 5.40	10	✓	m-Eslon	
Cap long-acting 100 mg 6.38	10	✓	m-Eslon	
Inj 5 mg per ml, 1 ml ampoule – Up to 5 inj available on a PSO 6.27	5	✓	DBL Morphine Sulphate	
Inj 10 mg per ml, 1 ml ampoule – Up to 5 inj available on a PSO 4.47	5	✓	DBL Morphine Sulphate	
Inj 15 mg per ml, 1 ml ampoule – Up to 5 inj available on a PSO 4.76	5	✓	DBL Morphine Sulphate	
Inj 30 mg per ml, 1 ml ampoule – Up to 5 inj available on a PSO 6.19	5	✓	DBL Morphine Sulphate	
MORPHINE TARTRATE				
a) Only on a controlled drug form				
b) No patient co-payment payable				
c) Safety medicine; prescriber may determine dispensing frequency				
Inj 80 mg per ml, 1.5 ml ampoule 42.72	5	✓	DBL Morphine Tartrate	

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
OXYCODONE HYDROCHLORIDE				
a) Only on a controlled drug form				
b) No patient co-payment payable				
c) Safety medicine; prescriber may determine dispensing frequency				
Tab controlled-release 5 mg.....	2.63	20	✓	BNM
Tab controlled-release 10 mg.....	2.76	20	✓	BNM
Tab controlled-release 20 mg.....	4.72	20	✓	BNM
Tab controlled-release 40 mg.....	7.69	20	✓	BNM
Tab controlled-release 80 mg.....	14.11	20	✓	BNM
Cap immediate-release 5 mg.....	1.88	20	✓	OxyNorm
Cap immediate-release 10 mg.....	3.32	20	✓	OxyNorm
Cap immediate-release 20 mg.....	5.81	20	✓	OxyNorm
Oral liq 5 mg per 5 ml.....	11.20	250 ml	✓	OxyNorm
Inj 10 mg per ml, 1 ml ampoule.....	7.28	5	✓	OxyNorm
Inj 10 mg per ml, 2 ml ampoule.....	14.36	5	✓	OxyNorm
Inj 50 mg per ml, 1 ml ampoule.....	30.60	5	✓	OxyNorm

PARACETAMOL WITH CODEINE – Safety medicine; prescriber may determine dispensing frequency

* Tab paracetamol 500 mg with codeine phosphate 8 mg.....	18.21	1,000	✓	Paracetamol + Codeine (Relieve)
---	-------	-------	---	--

PETHIDINE HYDROCHLORIDE

a) Only on a controlled drug form				
b) No patient co-payment payable				
c) Safety medicine; prescriber may determine dispensing frequency				
Tab 50 mg.....	4.46	10	✓	PSM
Inj 50 mg per ml, 1 ml ampoule – Up to 5 inj available on a PSO.....	4.98	5	✓	DBL Pethidine Hydrochloride
Inj 50 mg per ml, 2 ml ampoule – Up to 5 inj available on a PSO.....	5.12	5	✓	DBL Pethidine Hydrochloride

TRAMADOL HYDROCHLORIDE

Tab sustained-release 100 mg.....	1.55	20	✓	Tramal SR 100
Tab sustained-release 150 mg.....	2.10	20	✓	Tramal SR 150
Tab sustained-release 200 mg.....	2.75	20	✓	Tramal SR 200
Cap 50 mg.....	2.25	100	✓	Arrow-Tramadol

Antidepressants

Cyclic and Related Agents

AMITRIPTYLINE – Safety medicine; prescriber may determine dispensing frequency

Tab 10 mg.....	1.96	100	✓	Arrow-Amitriptyline
Tab 25 mg.....	1.52	100	✓	Arrow-Amitriptyline
Tab 50 mg.....	2.51	100	✓	Arrow-Amitriptyline

CLOMIPRAMINE HYDROCHLORIDE – Safety medicine; prescriber may determine dispensing frequency

Tab 10 mg.....	13.99	100	✓	Apo-Clomipramine
Tab 25 mg.....	9.46	100	✓	Apo-Clomipramine

DOSULEPIN [DOTHIEPIN] HYDROCHLORIDE – Safety medicine; prescriber may determine dispensing frequency

Tab 75 mg.....	11.19	100	✓	Dopress
Cap 25 mg.....	6.45	100	✓	Dopress

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

NERVOUS SYSTEM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
DOXEPIN HYDROCHLORIDE – Safety medicine; prescriber may determine dispensing frequency				
Cap 10 mg	6.30	100	✓	Anten
Cap 25 mg	6.86	100	✓	Anten
Cap 50 mg	8.55	100	✓	Anten
IMIPRAMINE HYDROCHLORIDE – Safety medicine; prescriber may determine dispensing frequency				
Tab 10 mg	5.48	50	✓	Tofranil
	6.58	60	✓	Tofranil s29 ^{s29}
	10.96	100	✓	Tofranil
Tab 25 mg	8.80	50	✓	Tofranil
<i>(Tofranil s29 ^{s29} Tab 10 mg to be delisted 1 February 2019)</i>				
MAPROTILINE HYDROCHLORIDE – Safety medicine; prescriber may determine dispensing frequency				
Tab 25 mg	7.52	30	✓	Ludiomil
	12.53	50	✓	Ludiomil
	25.06	100	✓	Ludiomil
Tab 75 mg	14.01	20	✓	Ludiomil
	21.01	30	✓	Ludiomil
NORTRIPTYLINE HYDROCHLORIDE – Safety medicine; prescriber may determine dispensing frequency				
Tab 10 mg	3.22	100	✓	Norpress
Tab 25 mg	7.08	180	✓	Norpress

Monoamine-Oxidase Inhibitors (MAOIs) - Non Selective

PHENELZINE SULPHATE				
* Tab 15 mg	95.00	100	✓	Nardil
TRANLYCYPROMINE SULPHATE				
* Tab 10 mg	22.94	50	✓	Parnate

Monoamine-Oxidase Type A Inhibitors

MOCLOBEMIDE				
* Tab 150 mg	85.10	500	✓	Apo-Moclobemide
* Tab 300 mg	30.70	100	✓	Apo-Moclobemide

Selective Serotonin Reuptake Inhibitors

CITALOPRAM HYDROBROMIDE				
* Tab 20 mg	1.52	84	✓	PSM Citalopram
ESCITALOPRAM				
* Tab 10 mg	1.11	28	✓	Escitalopram- Apotex
* Tab 20 mg	1.90	28	✓	Escitalopram- Apotex

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
FLUOXETINE HYDROCHLORIDE				
* Tab dispersible 20 mg, scored – Subsidy by endorsement.....	2.47	30	✓	Arrow-Fluoxetine
Subsidised by endorsement				
1) When prescribed for a patient who cannot swallow whole tablets or capsules and the prescription is endorsed accordingly; or				
2) When prescribed in a daily dose that is not a multiple of 20 mg in which case the prescription is deemed to be endorsed. Note: Tablets should be combined with capsules to facilitate incremental 10 mg doses.				
* Cap 20 mg	1.99	90	✓	Arrow-Fluoxetine
PAROXETINE				
* Tab 20 mg	4.02	90	✓	Apo-Paroxetine
SERTRALINE				
* Tab 50 mg	3.05	90	✓	Arrow-Sertraline
* Tab 100 mg	5.25	90	✓	Arrow-Sertraline

Other Antidepressants

MIRTAZAPINE				
Tab 30 mg	2.63	30	✓	Apo-Mirtazapine
Tab 45 mg	3.48	30	✓	Apo-Mirtazapine
VENLAFAXINE				
* Cap 37.5 mg	6.38	84	✓	Enlifax XR
* Cap 75 mg	8.11	84	✓	Enlifax XR
* Cap 150 mg	11.16	84	✓	Enlifax XR

Antiepilepsy Drugs

Agents for Control of Status Epilepticus

CLONAZEPAM – Safety medicine; prescriber may determine dispensing frequency				
Inj 1 mg per ml, 1 ml	21.00	5	✓	Rivotril
DIAZEPAM – Safety medicine; prescriber may determine dispensing frequency				
Inj 5 mg per ml, 2 ml ampoule – Subsidy by endorsement.....	11.83	5	✓	Hospira
a) Up to 5 inj available on a PSO				
b) Only on a PSO				
c) PSO must be endorsed "not for anaesthetic procedures".				
Rectal tubes 5 mg – Up to 5 tube available on a PSO	33.07	5	✓	Stesolid
Rectal tubes 10 mg – Up to 5 tube available on a PSO	40.87	5	✓	Stesolid
PARALDEHYDE				
* Inj 5 ml	1,500.00	5	✓	AFT <small>\$29</small>
PHENYTOIN SODIUM				
* Inj 50 mg per ml, 2 ml ampoule – Up to 5 inj available on a PSO	88.63	5	✓	Hospira
* Inj 50 mg per ml, 5 ml ampoule – Up to 5 inj available on a PSO	133.92	5	✓	Hospira

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
Control of Epilepsy				
CARBAMAZEPINE				
* Tab 200 mg	14.53	100	✓	Tegretol
* Tab long-acting 200 mg	16.98	100	✓	Tegretol CR
* Tab 400 mg	34.58	100	✓	Tegretol
* Tab long-acting 400 mg	39.17	100	✓	Tegretol CR
* Oral liq 20 mg per ml	26.37	250 ml	✓	Tegretol
CLOBAZAM – Safety medicine; prescriber may determine dispensing frequency				
Tab 10 mg	9.12	50	✓	Frisium
CLONAZEPAM – Safety medicine; prescriber may determine dispensing frequency				
Oral drops 2.5 mg per ml	7.38	10 ml OP	✓	Rivotril
ETHOSUXIMIDE				
Cap 250 mg	281.75	200	✓	Zarontin
Oral liq 250 mg per 5 ml	56.35	200 ml	✓	Zarontin
GABAPENTIN – Brand switch fee payable (Pharmacode 2556626) - see page 213 for details				
Note: Not subsidised in combination with subsidised pregabalin				
* Cap 100 mg	2.65	100	✓	Apo-Gabapentin
* Cap 300 mg	4.07	100	✓	Apo-Gabapentin
* Cap 400 mg	5.64	100	✓	Apo-Gabapentin
LACOSAMIDE – Special Authority see SA1125 below – Retail pharmacy				
▲ Tab 50 mg	25.04	14	✓	Vimpat
▲ Tab 100 mg	50.06	14	✓	Vimpat
	200.24	56	✓	Vimpat
▲ Tab 150 mg	75.10	14	✓	Vimpat
	300.40	56	✓	Vimpat
▲ Tab 200 mg	400.55	56	✓	Vimpat

►SA1125 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 15 months for applications meeting the following criteria:
Both:

- 1 Patient has partial-onset epilepsy; and
- 2 Seizures are not adequately controlled by, or patient has experienced unacceptable side effects from, optimal treatment with all of the following: sodium valproate, topiramate, levetiracetam and any two of carbamazepine, lamotrigine and phenytoin sodium (see Note).

Note: "Optimal treatment" is defined as treatment which is indicated and clinically appropriate for the patient, given in adequate doses for the patient's age, weight and other features affecting the pharmacokinetics of the drug with good evidence of compliance. Women of childbearing age are not required to have a trial of sodium valproate.

Renewal from any relevant practitioner. Approvals valid for 24 months where the patient has demonstrated a significant and sustained improvement in seizure rate or severity and/or quality of life compared with that prior to starting lacosamide treatment (see Note).

Note: As a guideline, clinical trials have referred to a notional 50% reduction in seizure frequency as an indicator of success with anticonvulsant therapy and have assessed quality of life from the patient's perspective.

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
LAMOTRIGINE				
▲ Tab dispersible 2 mg	6.74	30	✓	Lamictal
▲ Tab dispersible 5 mg	9.64	30	✓	Lamictal
	15.00	56	✓	Arrow-Lamotrigine
▲ Tab dispersible 25 mg	19.38	56	✓	Logem
	20.40		✓	Arrow-Lamotrigine
	29.09		✓	Lamictal
▲ Tab dispersible 50 mg	32.97	56	✓	Logem
	34.70		✓	Arrow-Lamotrigine
	47.89		✓	Lamictal
▲ Tab dispersible 100 mg	56.91	56	✓	Logem
	59.90		✓	Arrow-Lamotrigine
	79.16		✓	Lamictal
LEVETIRACETAM				
Tab 250 mg	24.03	60	✓	Everet
Tab 500 mg	28.71	60	✓	Everet
Tab 750 mg	45.23	60	✓	Everet
Tab 1,000 mg	59.12	60	✓	Everet
Oral liq 100 mg per ml	44.78	300 ml OP	✓	Levetiracetam-AFT
PHENOBARBITONE				
For phenobarbitone oral liquid refer Standard Formulae, page 215				
* Tab 15 mg	40.00	500	✓	PSM
* Tab 30 mg	40.00	500	✓	PSM
PHENYTOIN SODIUM				
* Tab 50 mg	50.51	200	✓	Dilantin Infatab
Cap 30 mg	22.00	200	✓	Dilantin
Cap 100 mg	19.79	200	✓	Dilantin
Oral liq 30 mg per 5 ml	22.03	500 ml	✓	Dilantin
PREGABALIN				
Note: Not subsidised in combination with subsidised gabapentin				
* Cap 25 mg	2.25	56	✓	Pregabalin Pfizer
* Cap 75 mg	2.65	56	✓	Pregabalin Pfizer
* Cap 150 mg	4.01	56	✓	Pregabalin Pfizer
* Cap 300 mg	7.38	56	✓	Pregabalin Pfizer
PRIMIDONE				
* Tab 250 mg	17.25	100	✓	Apo-Primidone
	62.00	200	✓	Mysoline S29 ^{S29}
SODIUM VALPROATE				
Tab 100 mg	13.65	100	✓	Epilim Crushable
Tab 200 mg EC	27.44	100	✓	Epilim
Tab 500 mg EC	52.24	100	✓	Epilim
* Oral liq 200 mg per 5 ml	20.48	300 ml	✓	Epilim S/F Liquid
			✓	Epilim Syrup
			✓	Epilim IV
* Inj 100 mg per ml, 4 ml	41.50	1		
STIRIPENTOL – Special Authority see SA1330 on the next page – Retail pharmacy				
Cap 250 mg	509.29	60	✓	Diacomit ^{S29}
Powder for oral liq 250 mg sachet	509.29	60	✓	Diacomit ^{S29}

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

* Three months or six months, as applicable, dispensed all-at-once

►SA1330 Special Authority for Subsidy

Initial application only from a paediatric neurologist or Practitioner on the recommendation of a paediatric neurologist.

Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Patient has confirmed diagnosis of Dravet syndrome; and
- 2 Seizures have been inadequately controlled by appropriate courses of sodium valproate, clobazam and at least two of the following: topiramate, levetiracetam, ketogenic diet.

Renewal from any relevant practitioner. Approvals valid without further renewal unless notified where the patient continues to benefit from treatment as measured by reduced seizure frequency from baseline.

TOPIRAMATE

▲ Tab 25 mg	11.07	60	✓ Arrow-Topiramate ✓ Topiramate Actavis ✓ Topamax
	26.04		
▲ Tab 50 mg	18.81	60	✓ Arrow-Topiramate ✓ Topiramate Actavis ✓ Topamax
	44.26		
▲ Tab 100 mg	31.99	60	✓ Arrow-Topiramate ✓ Topiramate Actavis ✓ Topamax
	75.25		
▲ Tab 200 mg	55.19	60	✓ Arrow-Topiramate ✓ Topiramate Actavis ✓ Topamax
	129.85		
▲ Sprinkle cap 15 mg	20.84	60	✓ Topamax
▲ Sprinkle cap 25 mg	26.04	60	✓ Topamax

VIGABATRIN – Special Authority see [SA1072 below](#) – Retail pharmacy

▲ Tab 500 mg	119.30	100	✓ Sabril
--------------------	--------	-----	----------

►SA1072 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 15 months for applications meeting the following criteria:

Both:

- 1 Either:
 - 1.1 Patient has infantile spasms; or
 - 1.2 Both:
 - 1.2.1 Patient has epilepsy; and
 - 1.2.2 Either:
 - 1.2.2.1 Seizures are not adequately controlled with optimal treatment with other antiepilepsy agents; or
 - 1.2.2.2 Seizures are controlled adequately but the patient has experienced unacceptable side effects from optimal treatment with other antiepilepsy agents; and
- 2 Either:
 - 2.1 Patient is, or will be, receiving regular automated visual field testing (ideally before starting therapy and on a 6-monthly basis thereafter); or
 - 2.2 It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields.

Notes: "Optimal treatment with other antiepilepsy agents" is defined as treatment with other antiepilepsy agents which are indicated and clinically appropriate for the patient, given in adequate doses for the patient's age, weight, and other features affecting the pharmacokinetics of the drug with good evidence of compliance.

Vigabatrin is associated with a risk of irreversible visual field defects, which may be asymptomatic in the early stages.

Renewal from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

continued...

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
---	-----	--------------------------	-------------------------------------

continued...

Both:

- 1 The patient has demonstrated a significant and sustained improvement in seizure rate or severity and or quality of life; and
- 2 Either:
 - 2.1 Patient is receiving regular automated visual field testing (ideally every 6 months) on an ongoing basis for duration of treatment with vigabatrin; or
 - 2.2 It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields.

Notes: As a guideline, clinical trials have referred to a notional 50% reduction in seizure frequency as an indicator of success with anticonvulsant therapy and have assessed quality of life from the patient's perspective.

Vigabatrin is associated with a risk of irreversible visual field defects, which may be asymptomatic in the early stages.

Antimigraine Preparations

For Anti-inflammatory NSAIDs refer to MUSCULOSKELETAL, [page 112](#)

Acute Migraine Treatment

ERGOTAMINE TARTRATE WITH CAFFEINE

Tab 1 mg with caffeine 100 mg	31.00	100	✓ Cafergot ✓ Cafergot S29 <small>S29</small>
-------------------------------------	-------	-----	---

RIZATRIPTAN

Tab orodispersible 10 mg	5.26	30	✓ Rizamelt
--------------------------------	------	----	-------------------

SUMATRIPTAN

Tab 50 mg	24.44	100	✓ Apo-Sumatriptan
Tab 100 mg	46.23	100	✓ Apo-Sumatriptan
Inj 12 mg per ml, 0.5 ml prefilled pen – Maximum of 10 inj per prescription	42.67	2 OP	✓ Clustran ✓ Sun Pharma <small>S29</small>

Prophylaxis of Migraine

For Beta Adrenoceptor Blockers refer to CARDIOVASCULAR SYSTEM, [page 50](#)

PIZOTIFEN

* Tab 500 mcg	23.21	100	✓ Sandomigran ✓ Sandomigran S29 <small>S29</small>
---------------------	-------	-----	---

Antinausea and Vertigo Agents

For Antispasmodics refer to ALIMENTARY TRACT, [page 8](#)

APREPITANT – Special Authority see [SA0987](#) below – Retail pharmacy

Cap 2 × 80 mg and 1 × 125 mg	84.00	3 OP	✓ Emend Tri-Pack
------------------------------------	-------	------	-------------------------

► [SA0987](#) Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 12 months where the patient is undergoing highly emetogenic chemotherapy and/or anthracycline-based chemotherapy for the treatment of malignancy.

Renewal from any relevant practitioner. Approvals valid for 12 months where the patient is undergoing highly emetogenic chemotherapy and/or anthracycline-based chemotherapy for the treatment of malignancy.

BETAHISTINE DIHYDROCHLORIDE

* Tab 16 mg	2.89	84	✓ Vergo 16
-------------------	------	----	-------------------

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

* Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
CYCLIZINE HYDROCHLORIDE				
Tab 50 mg	0.55	10	✓	Nausicalm
	0.59	20	✓	Nauzene
<i>(Nauzene Tab 50 mg to be delisted 1 April 2019)</i>				
CYCLIZINE LACTATE				
Inj 50 mg per ml, 1 ml	14.95	5	✓	Nausicalm
DOMPERIDONE				
* Tab 10 mg	3.20	100	✓	Prokinex
HYOSCINE HYDROBROMIDE				
* Inj 400 mcg per ml, 1 ml ampoule	46.50	5	✓	Hospira
	93.00	10	✓	Martindale <small>S29</small>
Patch 1.5 mg – Special Authority see SA1387 below – Retail pharmacy	11.95	2	✓	Scopoderm TTS
►SA1387 Special Authority for Subsidy				
Initial application from any relevant practitioner. Approvals valid for 1 year for applications meeting the following criteria: Either:				
1 Control of intractable nausea, vomiting, or inability to swallow saliva in the treatment of malignancy or chronic disease where the patient cannot tolerate or does not adequately respond to oral anti-nausea agents; or				
2 Control of clozapine-induced hypersalivation where trials of at least two other alternative treatments have proven ineffective.				
Renewal from any relevant practitioner. Approvals valid for 1 year where the treatment remains appropriate and the patient is benefiting from treatment.				
METOCLOPRAMIDE HYDROCHLORIDE				
* Tab 10 mg	1.30	100	✓	Metoclopramide Actavis 10
* Inj 5 mg per ml, 2 ml ampoule – Up to 5 inj available on a PSO	4.50	10	✓	Pfizer
ONDANSETRON				
* Tab 4 mg	3.36	50	✓	Apo-Ondansetron
* Tab disp 4 mg	0.95	10	✓	Ondansetron ODT-ORLA
* Tab 8 mg	4.77	50	✓	Apo-Ondansetron
* Tab disp 8 mg	1.43	10	✓	Ondansetron ODT-DRLA
PROCHLORPERAZINE				
* Tab 3 mg buccal	5.97 (15.00)	50		Buccastem
* Tab 5 mg – Up to 30 tab available on a PSO	6.35	250	✓	Nausafix
* Inj 12.5 mg per ml, 1 ml – Up to 5 inj available on a PSO	25.81	10	✓	Stemetil
PROMETHAZINE THEOCLATE				
* Tab 25 mg	1.20 (5.59)	10		Avomine
<i>(Avomine Tab 25 mg to be delisted 1 March 2019)</i>				

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
Antipsychotics			
General			
AMISULPRIDE – Safety medicine; prescriber may determine dispensing frequency			
Tab 100 mg	4.56	30	✓ <u>Sulprix</u>
Tab 200 mg	14.75	60	✓ <u>Sulprix</u>
Tab 400 mg	27.70	60	✓ <u>Sulprix</u>
Oral liq 100 mg per ml	65.53	60 ml	✓ <u>Solian</u>
ARIPRAZOLE			
a) Brand switch fee payable (Pharmacode 2556634) - see page 213 for details			
b) Safety medicine; prescriber may determine dispensing frequency			
Tab 5 mg	17.50	30	✓ <u>Aripiprazole Sandoz</u>
Tab 10 mg	17.50	30	✓ <u>Aripiprazole Sandoz</u>
Tab 15 mg	17.50	30	✓ <u>Aripiprazole Sandoz</u>
Tab 20 mg	17.50	30	✓ <u>Aripiprazole Sandoz</u>
Tab 30 mg	17.50	30	✓ <u>Aripiprazole Sandoz</u>
CHLORPROMAZINE HYDROCHLORIDE – Safety medicine; prescriber may determine dispensing frequency			
Tab 10 mg – Up to 30 tab available on a PSO	12.36	100	✓ <u>Largactil</u>
Tab 25 mg – Up to 30 tab available on a PSO	13.02	100	✓ <u>Largactil</u>
Tab 100 mg – Up to 30 tab available on a PSO	30.61	100	✓ <u>Largactil</u>
Inj 25 mg per ml, 2 ml – Up to 5 inj available on a PSO	25.66	10	✓ <u>Largactil</u>
CLOZAPINE – Hospital pharmacy [HP4]			
Safety medicine; prescriber may determine dispensing frequency			
Tab 25 mg	5.69	50	✓ <u>Clozaril</u>
	6.69		✓ <u>Clopine</u>
	11.36	100	✓ <u>Clozaril</u>
	13.37		✓ <u>Clopine</u>
Tab 50 mg	8.67	50	✓ <u>Clopine</u>
	17.33	100	✓ <u>Clopine</u>
Tab 100 mg	14.73	50	✓ <u>Clozaril</u>
	17.33		✓ <u>Clopine</u>
	29.45	100	✓ <u>Clozaril</u>
	34.65		✓ <u>Clopine</u>
Tab 200 mg	34.65	50	✓ <u>Clopine</u>
	69.30	100	✓ <u>Clopine</u>
Suspension 50 mg per ml	17.33	100 ml	✓ <u>Clopine</u>
HALOPERIDOL – Safety medicine; prescriber may determine dispensing frequency			
Tab 500 mcg – Up to 30 tab available on a PSO	6.23	100	✓ <u>Serenace</u>
Tab 1.5 mg – Up to 30 tab available on a PSO	9.43	100	✓ <u>Serenace</u>
Tab 5 mg – Up to 30 tab available on a PSO	29.72	100	✓ <u>Serenace</u>
Oral liq 2 mg per ml – Up to 200 ml available on a PSO	23.84	100 ml	✓ <u>Serenace</u>
Inj 5 mg per ml, 1 ml ampoule – Up to 5 inj available on a PSO	21.55	10	✓ <u>Serenace</u>
LEVOMEPRMAZINE HYDROCHLORIDE – Safety medicine; prescriber may determine dispensing frequency			
Inj 25 mg per ml, 1 ml ampoule	47.89	10	✓ <u>Wockhardt</u>
LEVOMEPRMAZINE MALEATE – Safety medicine; prescriber may determine dispensing frequency			
Tab 25 mg	16.93	100	✓ <u>Nozinan</u>
Tab 100 mg	43.96	100	✓ <u>Nozinan</u>

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

* Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
LITHIUM CARBONATE – Safety medicine; prescriber may determine dispensing frequency				
Tab 250 mg	34.30	500	✓	Lithicarb FC
Tab 400 mg	12.83	100	✓	Lithicarb FC
Tab long-acting 400 mg	19.20	100	✓	Priadel
Cap 250 mg	9.42	100	✓	Douglas
<i>(Lithicarb FC Tab 400 mg to be delisted 1 March 2019)</i>				
OLANZAPINE – Safety medicine; prescriber may determine dispensing frequency				
Tab 2.5 mg	0.64	28	✓	Zypine
Tab 5 mg	1.15	28	✓	Zypine
Tab orodispersible 5 mg	1.25	28	✓	Zypine ODT
Tab 10 mg	1.65	28	✓	Zypine
Tab orodispersible 10 mg	2.05	28	✓	Zypine ODT
PERICAZINE – Safety medicine; prescriber may determine dispensing frequency				
Tab 2.5 mg	10.49	84	✓	Neulactil
	12.49	100	✓	Neulactil
Tab 10 mg	37.34	84	✓	Neulactil
	44.45	100	✓	Neulactil
QUETIAPINE – Safety medicine; prescriber may determine dispensing frequency				
Tab 25 mg	1.79	90	✓	Quetapel
Tab 100 mg	3.45	90	✓	Quetapel
Tab 200 mg	5.75	90	✓	Quetapel
Tab 300 mg	9.60	90	✓	Quetapel
RISPERIDONE – Safety medicine; prescriber may determine dispensing frequency				
Tab 0.5 mg	1.86	60	✓	Actavis
Tab 1 mg	2.06	60	✓	Actavis
Tab 2 mg	2.29	60	✓	Actavis
Tab 3 mg	2.50	60	✓	Actavis
Tab 4 mg	3.43	60	✓	Actavis
Oral liq 1 mg per ml	7.66	30 ml	✓	Risperon
ZIPRASIDONE – Safety medicine; prescriber may determine dispensing frequency				
Cap 20 mg	14.50	60	✓	Zusdone
	14.56		✓	Zeldox
Cap 40 mg	24.70	60	✓	Zusdone
Cap 60 mg	33.80	60	✓	Zusdone
Cap 80 mg	39.70	60	✓	Zusdone
<i>(Zeldox Cap 20 mg to be delisted 1 March 2019)</i>				
ZUCLOPENTHIXOL HYDROCHLORIDE – Safety medicine; prescriber may determine dispensing frequency				
Tab 10 mg	31.45	100	✓	Clopixol

Depot Injections

FLUPENTHIXOL DECANOATE – Safety medicine; prescriber may determine dispensing frequency				
Inj 20 mg per ml, 1 ml – Up to 5 inj available on a PSO	13.14	5	✓	Fluanxol
Inj 20 mg per ml, 2 ml – Up to 5 inj available on a PSO	20.90	5	✓	Fluanxol
Inj 100 mg per ml, 1 ml – Up to 5 inj available on a PSO	40.87	5	✓	Fluanxol
HALOPERIDOL DECANOATE – Safety medicine; prescriber may determine dispensing frequency				
Inj 50 mg per ml, 1 ml – Up to 5 inj available on a PSO	28.39	5	✓	Haldol
Inj 100 mg per ml, 1 ml – Up to 5 inj available on a PSO	55.90	5	✓	Haldol Concentrate
			✓	Haldol
Decanoates §29				

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
OLANZAPINE – Special Authority see SA1428 below – Retail pharmacy				
Safety medicine; prescriber may determine dispensing frequency				
Inj 210 mg vial	252.00	1	✓	Zyprexa Relprevv
Inj 300 mg vial	414.00	1	✓	Zyprexa Relprevv
Inj 405 mg vial	504.00	1	✓	Zyprexa Relprevv

► **SA1428** **Special Authority for Subsidy**

Initial application from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:
Either:

- 1 The patient has had an initial Special Authority approval for paliperidone depot injection or risperidone depot injection; or
- 2 All of the following:
 - 2.1 The patient has schizophrenia; and
 - 2.2 The patient has tried but failed to comply with treatment using oral atypical antipsychotic agents; and
 - 2.3 The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in the last 12 months.

Renewal from any relevant practitioner. Approvals valid for 12 months where the initiation of olanzapine depot injection has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of an atypical antipsychotic depot injection.

Note: The patient should be monitored for post-injection syndrome for at least two hours after each injection.

PALIPERIDONE – Special Authority see [SA1429 below](#) – Retail pharmacy

Safety medicine; prescriber may determine dispensing frequency

Inj 25 mg syringe	194.25	1	✓	Invega Sustenna
Inj 50 mg syringe	271.95	1	✓	Invega Sustenna
Inj 75 mg syringe	357.42	1	✓	Invega Sustenna
Inj 100 mg syringe	435.12	1	✓	Invega Sustenna
Inj 150 mg syringe	435.12	1	✓	Invega Sustenna

► **SA1429** **Special Authority for Subsidy**

Initial application from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:
Either:

- 1 The patient has had an initial Special Authority approval for risperidone depot injection or olanzapine depot injection; or
- 2 All of the following:
 - 2.1 The patient has schizophrenia or other psychotic disorder; and
 - 2.2 Has tried but failed to comply with treatment using oral atypical antipsychotic agents; and
 - 2.3 Has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in last 12 months.

Renewal from any relevant practitioner. Approvals valid for 12 months where the initiation of paliperidone depot injection has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of an atypical antipsychotic depot injection.

Note: Paliperidone depot injection should ideally be used as monotherapy (i.e. without concurrent use of any other antipsychotic medication). In some cases, it may be clinically appropriate to attempt to treat a patient with typical antipsychotic agents in depot injectable form before trialling paliperidone depot injection.

PIPTHIAZINE PALMITATE – Subsidy by endorsement

- a) Safety medicine; prescriber may determine dispensing frequency
- b) Subsidised for patients who were taking pipothiazine palmitate prior to 1 August 2014 and the prescription or PSO is endorsed accordingly. Pharmacists may annotate the prescription as endorsed where there exists a record of prior dispensing of pipothiazine palmitate.

Inj 50 mg per ml, 1 ml – Up to 5 inj available on a PSO	178.48	10	✓	Piportil
Inj 50 mg per ml, 2 ml – Up to 5 inj available on a PSO	353.32	10	✓	Piportil

(Piportil Inj 50 mg per ml, 1 ml to be delisted 1 June 2019)

(Piportil Inj 50 mg per ml, 2 ml to be delisted 1 June 2019)

NERVOUS SYSTEM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
RISPERIDONE – Special Authority see SA1427 below – Retail pharmacy				
Safety medicine; prescriber may determine dispensing frequency				
Inj 25 mg vial	135.98	1	✓	Risperdal Consta
Inj 37.5 mg vial	178.71	1	✓	Risperdal Consta
Inj 50 mg vial	217.56	1	✓	Risperdal Consta

➔ [SA1427](#) Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Either:

- 1 The patient has had an initial Special Authority approval for paliperidone depot injection or olanzapine depot injection; or
- 2 All of the following:
 - 2.1 The patient has schizophrenia or other psychotic disorder; and
 - 2.2 Has tried but failed to comply with treatment using oral atypical antipsychotic agents; and
 - 2.3 Has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in last 12 months.

Renewal from any relevant practitioner. Approvals valid for 12 months where the initiation of risperidone depot injection has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of an atypical antipsychotic depot injection.

Note: Risperidone depot injection should ideally be used as monotherapy (i.e. without concurrent use of any other antipsychotic medication). In some cases, it may be clinically appropriate to attempt to treat a patient with typical antipsychotic agents in depot injectable form before trialing risperidone depot injection.

ZUCLOPENTHIXOL DECANOATE – Safety medicine; prescriber may determine dispensing frequency

Inj 200 mg per ml, 1 ml – Up to 5 inj available on a PSO	19.80	5	✓	Clopixol
--	-------	---	---	-----------------

Anxiolytics

BUSPIRONE HYDROCHLORIDE

* Tab 5 mg	20.23	100	✓	Orion
* Tab 10 mg	13.16	100	✓	Orion

CLONAZEPAM – Safety medicine; prescriber may determine dispensing frequency

Tab 500 mcg	5.64	100	✓	Paxam
Tab 2 mg	10.78	100	✓	Paxam

DIAZEPAM – Safety medicine; prescriber may determine dispensing frequency

Tab 2 mg	15.05	500	✓	Arrow-Diazepam
Tab 5 mg	16.18	500	✓	Arrow-Diazepam

LORAZEPAM – Safety medicine; prescriber may determine dispensing frequency

Tab 1 mg	9.72	250	✓	Ativan
Tab 2.5 mg	12.50	100	✓	Ativan

OXAZEPAM – Safety medicine; prescriber may determine dispensing frequency

Tab 10 mg	6.17	100	✓	Ox-Pam
Tab 15 mg	8.53	100	✓	Ox-Pam

Multiple Sclerosis Treatments

DIMETHYL FUMARATE – Special Authority see [SA1559 on the next page](#) – Retail pharmacy

Wastage claimable

Cap 120 mg	520.00	14	✓	Tecfidera
Cap 240 mg	2,000.00	56	✓	Tecfidera

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

►SA1559 Special Authority for Subsidy

Special Authority approved by the Multiple Sclerosis Treatment Committee

Notes: Special Authority approved by the Multiple Sclerosis Treatment Assessment Committee (MSTAC). Applications will be considered by MSTAC at its regular meetings and approved subject to eligibility according to the Entry and Stopping criteria (below).

Application details may be obtained from PHARMAC's website <http://www.pharmac.govt.nz> or:

The coordinator	Phone: 04 460 4990
Multiple Sclerosis Treatment Assessment Committee	Facsimile: 04 916 7571
PHARMAC PO Box 10 254	Email: mstaccoordinator@pharmac.govt.nz
Wellington	

Completed application forms must be sent to the coordinator for MSTAC and will be considered by MSTAC at the next practicable opportunity.

Notification of MSTAC's decision will be sent to the patient, the applying clinician and the patient's GP (if specified).

Entry Criteria

- a) Diagnosis of multiple sclerosis (MS) must be confirmed by a neurologist. Diagnosis must include MRI confirmation; and
- b) patients must have Clinically Definite Relapsing Remitting MS with or without underlying progression; and
- c) patients must have:
 - a) EDSS score 0 - 4.0 and:
 - Experienced at least 1 significant relapse of MS in the previous 12 months or 2 significant relapses in the past 24 months; and
 - Evidence of new inflammatory activity on an MR scan within the past 24 months, any of the following:
 - i) a gadolinium enhancing lesion; or
 - ii) a Diffusion Weighted Imaging positive lesion; or
 - iii) a T2 lesion with associated local swelling; or
 - iv) a prominent T2 lesion that clearly is responsible for the clinical features of a recent relapse; or
 - v) new T2 lesions compared with a previous MR scan; and
- d) A significant relapse must:
 - a) be confirmed by the applying neurologist or general physician (the patient may not necessarily have been seen by them during the relapse but the neurologist/physician must be satisfied that the clinical features were characteristic and met the specified criteria);
 - b) be associated with characteristic new symptom(s)/sign(s) or substantial worsening of previously experienced symptom(s)/sign(s);
 - c) last at least one week;
 - d) start at least one month after the onset of a previous relapse;
 - e) be severe enough to change either the EDSS or at least one of the Kurtzke Functional System scores by at least 1 point;
 - f) be distinguishable from the effects of general fatigue; and
 - g) not be associated with a fever ($T > 37.5^{\circ}\text{C}$); and
- e) applications must be made by the patient's neurologist or general physician; and
- f) patients must have no previous history of lack of response to dimethyl fumarate; and
- g) patients must have not previously had intolerance to dimethyl fumarate; and
- h) patient must not be co-prescribed beta interferon or glatiramer acetate.

Stopping Criteria

Any of the following:

- 1) Confirmed progression of disability that is sustained for six months. Progression of disability is defined as progress by any of the following EDDSS points:

continued...

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
---	-----	--------------------------	-------------------------------------

continued...

- from starting at EDSS 0 increasing to (i.e. stopping on reaching) EDSS 3.0; or
 - 1.0 to 3.0; or
 - 1.5 to 3.5; or
 - 2.0 to 4.0; or
 - 2.5 to 4.5; or
 - 3.0 to 4.5; or
 - 3.5 to 4.5; or
 - 4.0 to 4.5.
- increasing relapse rate over 12 months of treatment (compared with the relapse rate on starting treatment)(see note); or
 - intolerance to dimethyl fumarate; or
 - non-compliance with treatment, including refusal to undergo annual assessment.

Note: Switching between natalizumab, fingolimod, dimethyl fumarate and teriflunomide is permitted provided the EDSS stopping criteria are not met. Switching to interferon or glatiramer acetate is only permitted provided the EDSS stopping criteria are not met and both fingolimod and natalizumab are either not tolerated or treatment with both agents would be clinically inappropriate. Continued relapses on treatment would be expected to lead to a switch of treatment provided the stopping criteria are not met. If a relapse has resulted in an increased EDSS score that potentially may lead to discontinuation of treatment according to stopping criteria, a period of 6 months is allowed from the start of the relapse for recovery to occur.

FINGOLIMOD – Special Authority see [SA1562 below](#) – Retail pharmacy

Wastage claimable

Cap 0.5 mg	2,200.00	28	✓ Gilenya
------------------	----------	----	-----------

►SA1562 Special Authority for Subsidy

Special Authority approved by the Multiple Sclerosis Treatment Committee

Notes: Special Authority approved by the Multiple Sclerosis Treatment Assessment Committee (MSTAC). Applications will be considered by MSTAC at its regular meetings and approved subject to eligibility according to the Entry and Stopping criteria (below).

Application details may be obtained from PHARMAC's website <http://www.pharmac.govt.nz> or:

The coordinator

Phone: 04 460 4990

Multiple Sclerosis Treatment Assessment Committee

Facsimile: 04 916 7571

PHARMAC PO Box 10 254

Email: mstaccoordinator@pharmac.govt.nz

Wellington

Completed application forms must be sent to the coordinator for MSTAC and will be considered by MSTAC at the next practicable opportunity.

Notification of MSTAC's decision will be sent to the patient, the applying clinician and the patient's GP (if specified).

Entry Criteria

- Diagnosis of multiple sclerosis (MS) must be confirmed by a neurologist. Diagnosis must include MRI confirmation; and
- patients must have Clinically Definite Relapsing Remitting MS with or without underlying progression; and
- patients must have:
 - EDSS score 0 - 4.0 and:
 - Experienced at least 1 significant relapse of MS in the previous 12 months or 2 significant relapses in the past 24 months; and
 - Evidence of new inflammatory activity on an MR scan within the past 24 months, any of the following:
 - a gadolinium enhancing lesion; or
 - a Diffusion Weighted Imaging positive lesion; or
 - a T2 lesion with associated local swelling; or
 - a prominent T2 lesion that clearly is responsible for the clinical features of a recent relapse; or
 - new T2 lesions compared with a previous MR scan; and

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

- 4) A significant relapse must:
 - a) be confirmed by the applying neurologist or general physician (the patient may not necessarily have been seen by them during the relapse but the neurologist/physician must be satisfied that the clinical features were characteristic and met the specified criteria);
 - b) be associated with characteristic new symptom(s)/sign(s) or substantial worsening of previously experienced symptom(s)/sign(s);
 - c) last at least one week;
 - d) start at least one month after the onset of a previous relapse;
 - e) be severe enough to change either the EDSS or at least one of the Kurtzke Functional System scores by at least 1 point;
 - f) be distinguishable from the effects of general fatigue; and
 - g) not be associated with a fever ($T > 37.5^{\circ}\text{C}$); and
- 5) applications must be made by the patient's neurologist or general physician; and
- 6) patients must have no previous history of lack of response to fingolimod; and
- 7) patients must have not previously had intolerance to fingolimod; and
- 8) patient must not be co-prescribed beta interferon or glatiramer acetate.

Stopping Criteria**Any of the following:**

- 1) Confirmed progression of disability that is sustained for six months. Progression of disability is defined as progress by any of the following EDSS points:
 - a) from starting at EDSS 0 increasing to (i.e. stopping on reaching) EDSS 3.0; or
 - b) 1.0 to 3.0; or
 - c) 1.5 to 3.5; or
 - d) 2.0 to 4.0; or
 - e) 2.5 to 4.5; or
 - f) 3.0 to 4.5; or
 - g) 3.5 to 4.5; or
 - h) 4.0 to 4.5.
- 2) increasing relapse rate over 12 months of treatment (compared with the relapse rate on starting treatment)(see note); or
- 3) intolerance to fingolimod; or
- 4) non-compliance with treatment, including refusal to undergo annual assessment.

Note: Switching between natalizumab, fingolimod, dimethyl fumarate and teriflunomide is permitted provided the EDSS stopping criteria are not met. Switching to interferon or glatiramer acetate is only permitted provided the EDSS stopping criteria are not met and both fingolimod and natalizumab are either not tolerated or treatment with both agents would be clinically inappropriate. Continued relapses on treatment would be expected to lead to a switch of treatment provided the stopping criteria are not met. If a relapse has resulted in an increased EDSS score that potentially may lead to discontinuation of treatment according to stopping criteria, a period of 6 months is allowed from the start of the relapse for recovery to occur.

NATALIZUMAB – Special Authority see [SA1563 below](#) – Retail pharmacy

Inj 20 mg per ml, 15 ml vial..... 1,750.00 1 ✓ Tysabri

►SA1563 Special Authority for Subsidy

Special Authority approved by the Multiple Sclerosis Treatment Committee

Notes: Special Authority approved by the Multiple Sclerosis Treatment Assessment Committee (MSTAC). Applications will be considered by MSTAC at its regular meetings and approved subject to eligibility according to the Entry and Stopping criteria (below).

Application details may be obtained from PHARMAC's website <http://www.pharmac.govt.nz> or:

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

The coordinator

Phone: 04 460 4990

Multiple Sclerosis Treatment Assessment Committee

Facsimile: 04 916 7571

PHARMAC PO Box 10 254

Email: mstacordinator@pharmac.govt.nz

Wellington

Completed application forms must be sent to the coordinator for MSTAC and will be considered by MSTAC at the next practicable opportunity.

Notification of MSTAC's decision will be sent to the patient, the applying clinician and the patient's GP (if specified).

Entry Criteria

- 1) Diagnosis of multiple sclerosis (MS) must be confirmed by a neurologist. Diagnosis must include MRI confirmation; and
- 2) patients must have Clinically Definite Relapsing Remitting MS with or without underlying progression; and
- 3) patients must have:
 - a) EDSS score 0 - 4.0 and:
 - Experienced at least 1 significant relapse of MS in the previous 12 months or 2 significant relapses in the past 24 months; and
 - Evidence of new inflammatory activity on an MR scan within the past 24 months, any of the following:
 - i) a gadolinium enhancing lesion; or
 - ii) a Diffusion Weighted Imaging positive lesion; or
 - iii) a T2 lesion with associated local swelling; or
 - iv) a prominent T2 lesion that clearly is responsible for the clinical features of a recent relapse; or
 - v) new T2 lesions compared with a previous MR scan; and
- 4) A significant relapse must:
 - a) be confirmed by the applying neurologist or general physician (the patient may not necessarily have been seen by them during the relapse but the neurologist/physician must be satisfied that the clinical features were characteristic and met the specified criteria);
 - b) be associated with characteristic new symptom(s)/sign(s) or substantial worsening of previously experienced symptom(s)/sign(s);
 - c) last at least one week;
 - d) start at least one month after the onset of a previous relapse;
 - e) be severe enough to change either the EDSS or at least one of the Kurtzke Functional System scores by at least 1 point;
 - f) be distinguishable from the effects of general fatigue; and
 - g) not be associated with a fever ($T > 37.5^{\circ}\text{C}$); and
- 5) applications must be made by the patient's neurologist or general physician; and
- 6) treatment must be initiated and supervised by a neurologist who is registered in the Tysabri Australasian Prescribing Programme operated by the supplier; and
- 7) patients must have no previous history of lack of response to natalizumab; and
- 8) patients must have not previously had intolerance to natalizumab; and
- 9)
 - a) Patient is JC virus negative, or
 - b) Patient is JC virus positive and has given written informed consent acknowledging an understanding of the risk of progressive multifocal leucoencephalopathy (PML) associated with natalizumab
- 10) patient must not be co-prescribed beta interferon or glatiramer acetate.

Stopping Criteria

Any of the following:

- 1) Confirmed progression of disability that is sustained for six months. Progression of disability is defined as progress by any of the following EDDSS points:
 - a) from starting at EDSS 0 increasing to (i.e. stopping on reaching) EDSS 3.0; or

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

- b) 1.0 to 3.0; or
- c) 1.5 to 3.5; or
- d) 2.0 to 4.0; or
- e) 2.5 to 4.5; or
- f) 3.0 to 4.5; or
- g) 3.5 to 4.5; or
- h) 4.0 to 4.5.

- 2) increasing relapse rate over 12 months of treatment (compared with the relapse rate on starting treatment)(see note); or
- 3) intolerance to natalizumab; or
- 4) non-compliance with treatment, including refusal to undergo annual assessment.

Note: Natalizumab can only be dispensed from a pharmacy registered in the Tysabri Australasian Prescribing Programme operated by the supplier.

Switching between natalizumab, fingolimod, dimethyl fumarate and teriflunomide is permitted provided the EDSS stopping criteria are not met. Switching to interferon or glatiramer acetate is only permitted provided the EDSS stopping criteria are not met and both fingolimod and natalizumab are either not tolerated or treatment with both agents would be clinically inappropriate.

Continued relapses on treatment would be expected to lead to a switch of treatment provided the stopping criteria are not met. If a relapse has resulted in an increased EDSS score that potentially may lead to discontinuation of treatment according to stopping criteria, a period of 6 months is allowed from the start of the relapse for recovery to occur.

TERIFLUNOMIDE – Special Authority see [SA1560 below](#) – Retail pharmacy

Wastage claimable

Tab 14 mg	1,582.62	28	✓ Aubagio
-----------------	----------	----	-----------

► [SA1560](#) Special Authority for Subsidy

Special Authority approved by the Multiple Sclerosis Treatment Committee

Notes: Special Authority approved by the Multiple Sclerosis Treatment Assessment Committee (MSTAC). Applications will be considered by MSTAC at its regular meetings and approved subject to eligibility according to the Entry and Stopping criteria (below).

Application details may be obtained from PHARMAC's website <http://www.pharmac.govt.nz> or:

The coordinator

Phone: 04 460 4990

Multiple Sclerosis Treatment Assessment Committee

Facsimile: 04 916 7571

PHARMAC PO Box 10 254

Email: mstaccoordinator@pharmac.govt.nz

Wellington

Completed application forms must be sent to the coordinator for MSTAC and will be considered by MSTAC at the next practicable opportunity.

Notification of MSTAC's decision will be sent to the patient, the applying clinician and the patient's GP (if specified).

Entry Criteria

- 1) Diagnosis of multiple sclerosis (MS) must be confirmed by a neurologist. Diagnosis must include MRI confirmation; and
- 2) patients must have Clinically Definite Relapsing Remitting MS with or without underlying progression; and
- 3) patients must have:
 - a) EDSS score 0 - 4.0 and:
 - Experienced at least 1 significant relapse of MS in the previous 12 months or 2 significant relapses in the past 24 months; and
 - Evidence of new inflammatory activity on an MR scan within the past 24 months, any of the following:
 - i) a gadolinium enhancing lesion; or
 - ii) a Diffusion Weighted Imaging positive lesion; or
 - iii) a T2 lesion with associated local swelling; or
 - iv) a prominent T2 lesion that clearly is responsible for the clinical features of a recent relapse; or

continued...

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

* Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

- v) new T2 lesions compared with a previous MR scan; and
- 4) A significant relapse must:
- a) be confirmed by the applying neurologist or general physician (the patient may not necessarily have been seen by them during the relapse but the neurologist/physician must be satisfied that the clinical features were characteristic and met the specified criteria);
 - b) be associated with characteristic new symptom(s)/sign(s) or substantial worsening of previously experienced symptom(s)/sign(s);
 - c) last at least one week;
 - d) start at least one month after the onset of a previous relapse;
 - e) be severe enough to change either the EDSS or at least one of the Kurtzke Functional System scores by at least 1 point;
 - f) be distinguishable from the effects of general fatigue; and
 - g) not be associated with a fever (T> 37.5°C); and
- 5) applications must be made by the patient's neurologist or general physician; and
- 6) patients must have no previous history of lack of response to teriflunomide; and
- 7) patients must have not previously had intolerance to teriflunomide; and
- 8) patient must not be co-prescribed beta interferon or glatiramer acetate.

Stopping Criteria
Any of the following:

- 1) Confirmed progression of disability that is sustained for six months. Progression of disability is defined as progress by any of the following EDDSS points:
- a) from starting at EDSS 0 increasing to (i.e. stopping on reaching) EDSS 3.0; or
 - b) 1.0 to 3.0; or
 - c) 1.5 to 3.5; or
 - d) 2.0 to 4.0; or
 - e) 2.5 to 4.5; or
 - f) 3.0 to 4.5; or
 - g) 3.5 to 4.5; or
 - h) 4.0 to 4.5.
- 2) increasing relapse rate over 12 months of treatment (compared with the relapse rate on starting treatment)(see note); or
- 3) intolerance to teriflunomide; or
- 4) non-compliance with treatment, including refusal to undergo annual assessment.

Note: Switching between natalizumab, fingolimod, dimethyl fumarate and teriflunomide is permitted provided the EDSS stopping criteria are not met. Switching to interferon or glatiramer acetate is only permitted provided the EDSS stopping criteria are not met and both fingolimod and natalizumab are either not tolerated or treatment with both agents would be clinically inappropriate. Continued relapses on treatment would be expected to lead to a switch of treatment provided the stopping criteria are not met. If a relapse has resulted in an increased EDSS score that potentially may lead to discontinuation of treatment according to stopping criteria, a period of 6 months is allowed from the start of the relapse for recovery to occur.

Other Multiple Sclerosis Treatments

►SA1564 Special Authority for Subsidy

Special Authority approved by the Multiple Sclerosis Treatment Committee

Notes: Special Authority approved by the Multiple Sclerosis Treatment Assessment Committee (MSTAC). Applications will be considered by MSTAC at its regular meetings and approved subject to eligibility according to the Entry and Stopping criteria (below).

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

Application details may be obtained from PHARMAC's website <http://www.pharmac.govt.nz> or:

The coordinator	Phone: 04 460 4990
Multiple Sclerosis Treatment Assessment Committee	Facsimile: 04 916 7571
PHARMAC PO Box 10 254	Email: mstacordinator@pharmac.govt.nz
Wellington	

Completed application forms must be sent to the coordinator for MSTAC and will be considered by MSTAC at the next practicable opportunity.

Notification of MSTAC's decision will be sent to the patient, the applying clinician and the patient's GP (if specified).

These agents will NOT be subsidised if dispensed from a community or hospital pharmacy. Regular supplies will be distributed to all approved patients or their clinicians by courier.

Prescribers must send quarterly prescriptions for approved patients to the MSTAC coordinator.

Only prescriptions for 6 million iu of interferon beta-1-alpha per week, or 8 million iu of interferon beta-1-beta every other day, or 20 mg glatiramer acetate daily will be subsidised.

Switching between treatments is permitted within the 12 month approval period without reapproval by MSTAC. The MSTAC coordinator should be notified of the change and a new prescription provided.

Entry Criteria

- 1) Diagnosis of multiple sclerosis (MS) must be confirmed by a neurologist. Diagnosis must include MRI confirmation; and
- 2) patients must have Clinically Definite Relapsing Remitting MS with or without underlying progression; and
- 3) patients must have:
 - a) EDSS score 0 - 4.0 and:
 - Experienced at least 1 significant relapse of MS in the previous 12 months or 2 significant relapses in the past 24 months; and
 - Evidence of new inflammatory activity on an MR scan within the past 24 months, any of the following:
 - i) a gadolinium enhancing lesion; or
 - ii) a Diffusion Weighted Imaging positive lesion; or
 - iii) a T2 lesion with associated local swelling; or
 - iv) a prominent T2 lesion that clearly is responsible for the clinical features of a recent relapse; or
 - v) new T2 lesions compared with a previous MR scan; and
- 4) A significant relapse must:
 - a) be confirmed by the applying neurologist or general physician (the patient may not necessarily have been seen by them during the relapse but the neurologist/physician must be satisfied that the clinical features were characteristic and met the specified criteria);
 - b) be associated with characteristic new symptom(s)/sign(s) or substantial worsening of previously experienced symptom(s)/sign(s);
 - c) last at least one week;
 - d) start at least one month after the onset of a previous relapse;
 - e) be severe enough to change either the EDSS or at least one of the Kurtzke Functional System scores by at least 1 point;
 - f) be distinguishable from the effects of general fatigue; and
 - g) not be associated with a fever (T > 37.5°C); and
- 5) applications must be made by the patient's neurologist; and
- 6) patients must have no previous history of lack of response to beta-interferon or glatiramer acetate; and
- 7) patients must have either:
 - a) intolerance to both natalizumab and fingolimod; or
 - b) treatment with both natalizumab and fingolimod is considered clinically inappropriate; and
- 8) patient will not be co-prescribed natalizumab or fingolimod.

continued...

continued...

Stopping Criteria

Any of the following:

- Confirmed progression of disability that is sustained for six months during a minimum of one year of treatment.
Progression of disability is defined as progress by any of the following EDDS Points:
 - from starting at EDDS 0 increasing to (i.e. stopping on reaching) EDDS 3.0; or
 - 1.0 to 3.0; or
 - 1.5 to 3.5; or
 - 2.0 to 4.0; or
 - 2.5 to 4.5; or
 - 3.0 to 4.5; or
 - 3.5 to 4.5; or
 - 4.0 to 4.5.
- increasing relapse rate over 12 months of treatment (compared with the relapse rate on starting treatment)(see note); or
- intolerance to interferon beta-1-alpha, and/or interferon beta-1-beta and/or glatiramer acetate; or
- non-compliance with treatment, including refusal to undergo annual assessment.

Note: Treatment with interferon beta-1-beta, interferon beta-1-alpha and glatiramer acetate, is permitted only if treatment with both natalizumab and fingolimod is not tolerated or treatment with both would be clinically inappropriate. Beta-interferon or glatiramer acetate will not be funded as second line treatments if EDDS progression has occurred on treatment with natalizumab or fingolimod. Patients who have an increasing relapse rate over 12 months of treatment (compared with the relapse rate on starting treatment) and who do not meet the EDDS Stopping Criteria at annual review may switch from either of the beta-interferon's [interferon beta-1-beta or interferon beta-1-alpha] to glatiramer acetate or vice versa. Patients may switch from either of the beta-interferon's [interferon beta-1-beta or interferon beta-1-alpha] to glatiramer acetate or vice versa for increased relapses only once, after which they will be required to stop funded treatment if they meet any of the Stopping Criteria at annual review (including the criterion relating to increasing relapse rate over 12 months of treatment). If a relapse has resulted in an increased EDDS score that potentially may lead to discontinuation of treatment according to stopping criteria, a period of 6 months is allowed from the start of the relapse for recovery to occur. In this setting anti-JCV antibody positive status may be accepted as a clinically inappropriate reason for treatment with natalizumab.

GLATIRAMER ACETATE – Special Authority see [SA1564 on page 144](#) – [Xpharm]

Inj 20 mg prefilled syringe.....	2,250.00	28	✓ Copaxone
----------------------------------	----------	----	------------

INTERFERON BETA-1-ALPHA – Special Authority see [SA1564 on page 144](#) – [Xpharm]

Inj 6 million iu prefilled syringe.....	1,170.00	4	✓ Avonex
Injection 6 million iu per 0.5 ml pen injector.....	1,170.00	4	✓ Avonex Pen

INTERFERON BETA-1-BETA – Special Authority see [SA1564 on page 144](#) – [Xpharm]

Inj 8 million iu per 1 ml.....	1,322.89	15	✓ Betaferon
--------------------------------	----------	----	-------------

Sedatives and Hypnotics

LORMETAZEPAM – Safety medicine; prescriber may determine dispensing frequency

Tab 1 mg	3.11	30	Noctamid
	(23.50)		

(Noctamid Tab 1 mg to be delisted 1 March 2019)

MELATONIN – Special Authority see [SA1666 below](#) – Retail pharmacy

Tab modified-release 2 mg – No more than 5 tab per day	28.22	30	✓ Circadin
--	-------	----	------------

► [SA1666](#) Special Authority for Subsidy

Initial application only from a psychiatrist, paediatrician, neurologist, respiratory specialist or medical practitioner on the recommendation of a psychiatrist, paediatrician, neurologist or respiratory specialist. Approvals valid for 12 months for applications meeting the following criteria:

continued...

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
---	-----	--------------------------	-------------------------------------

continued...

All of the following:

- 1 Patient has been diagnosed with persistent and distressing insomnia secondary to a neurodevelopmental disorder (including, but not limited to, autism spectrum disorder or attention deficit hyperactivity disorder)*; and
- 2 Behavioural and environmental approaches have been tried and were unsuccessful, or are inappropriate; and
- 3 Funded modified-release melatonin is to be given at doses no greater than 10 mg per day; and
- 4 Patient is aged 18 years or under*.

Renewal only from a psychiatrist, paediatrician, neurologist, respiratory specialist or medical practitioner on the recommendation of a psychiatrist, paediatrician, neurologist or respiratory specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient is aged 18 years or under*; and
- 2 Patient has demonstrated clinically meaningful benefit from funded modified-release melatonin (clinician determined); and
- 3 Patient has had a trial of funded modified-release melatonin discontinuation within the past 12 months and has had a recurrence of persistent and distressing insomnia; and
- 4 Funded modified-release melatonin is to be given at doses no greater than 10 mg per day.

Note: Indications marked with * are unapproved indications.

MIDAZOLAM – Safety medicine; prescriber may determine dispensing frequency

Inj 1 mg per ml, 5 ml ampoule	4.30	10	✓ Midazolam-Clarix
Inj 1 mg per ml, 5 ml plastic ampoule – Up to 10 inj available on a PSO	14.90	10	✓ Pfizer
On a PSO for status epilepticus use only. PSO must be endorsed for status epilepticus use only.			
Inj 5 mg per ml, 3 ml ampoule	2.50	5	✓ Midazolam-Clarix
Inj 5 mg per ml, 3 ml plastic ampoule – Up to 5 inj available on a PSO	11.90	5	✓ Pfizer
On a PSO for status epilepticus use only. PSO must be endorsed for status epilepticus use only.			

NITRAZEPAM – Safety medicine; prescriber may determine dispensing frequency

Tab 5 mg	5.22	100	✓ Nitrados
----------------	------	-----	------------

PHENOBARBITONE SODIUM – Special Authority see [SA1386 below](#) – Retail pharmacy

Inj 200 mg per ml, 1 ml ampoule	46.20	10	✓ Martindale ^{S29}
---------------------------------------	-------	----	-----------------------------

➔ [SA1386](#) Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- 1 For the treatment of terminal agitation that is unresponsive to other agents; and
- 2 The applicant is part of a multidisciplinary team working in palliative care.

TEMAZEPAM – Safety medicine; prescriber may determine dispensing frequency

Tab 10 mg	1.27	25	✓ Normison
-----------------	------	----	------------

TRIAZOLAM – Safety medicine; prescriber may determine dispensing frequency

Tab 125 mcg	5.10	100	
	(9.85)		Hypam
Tab 250 mcg	4.10	100	
	(11.20)		Hypam

ZOPICLONE – Safety medicine; prescriber may determine dispensing frequency

Tab 7.5 mg	9.56	500	✓ Zopiclone Actavis
------------------	------	-----	---------------------

Zopiclone Actavis to be Sole Supply on 1 January 2019

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

* Three months or six months, as applicable, dispensed all-at-once

Stimulants/ADHD Treatments

ATOMOXETINE – Special Authority see [SA1416 below](#) – Retail pharmacy

Cap 10 mg	107.03	28	✓ Strattera
Cap 18 mg	107.03	28	✓ Strattera
Cap 25 mg	107.03	28	✓ Strattera
Cap 40 mg	107.03	28	✓ Strattera
Cap 60 mg	107.03	28	✓ Strattera
Cap 80 mg	139.11	28	✓ Strattera
Cap 100 mg	139.11	28	✓ Strattera

► [SA1416](#) Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has ADHD (Attention Deficit and Hyperactivity Disorder) diagnosed according to DSM-IV or ICD 10 criteria; and
- 2 Once-daily dosing; and
- 3 Any of the following:
 - 3.1 Treatment with a subsidised formulation of a stimulant has resulted in the development or worsening of serious adverse reactions or where the combination of subsidised stimulant treatment with another agent would pose an unacceptable medical risk; or
 - 3.2 Treatment with a subsidised formulation of a stimulant has resulted in worsening of co-morbid substance abuse or there is a significant risk of diversion with subsidised stimulant therapy; or
 - 3.3 An effective dose of a subsidised formulation of a stimulant has been trialled and has been discontinued because of inadequate clinical response; or
 - 3.4 Treatment with a subsidised formulation of a stimulant is considered inappropriate because the patient has a history of psychoses or has a first-degree relative with schizophrenia; and
- 4 The patient will not be receiving treatment with atomoxetine in combination with a subsidised formulation of a stimulant, except for the purposes of transitioning from subsidised stimulant therapy to atomoxetine.

Renewal from any relevant practitioner. Approvals valid for 2 years where the treatment remains appropriate and the patient is benefiting from treatment.

Note: A "subsidised formulation of a stimulant" refers to currently subsidised methylphenidate hydrochloride tablet formulations (immediate-release, sustained-release and extended-release) or dexamfetamine sulphate tablets.

DEXAMFETAMINE SULFATE – Special Authority see [SA1149 below](#) – Retail pharmacy

- a) Only on a controlled drug form
- b) Safety medicine; prescriber may determine dispensing frequency

Tab 5 mg	20.00	100	✓ PSM
----------------	-------	-----	--------------

► [SA1149](#) Special Authority for Subsidy

Initial application — (ADHD in patients 5 or over) only from a paediatrician, psychiatrist or medical practitioner on the recommendation of a paediatrician or psychiatrist (in writing). Approvals valid for 24 months for applications meeting the following criteria:

All of the following:

- 1 ADHD (Attention Deficit and Hyperactivity Disorder) patients aged 5 years or over; and
- 2 Diagnosed according to DSM-IV or ICD 10 criteria; and
- 3 Either:
 - 3.1 Applicant is a paediatrician or psychiatrist; or
 - 3.2 Applicant is a medical practitioner and confirms that a paediatrician or psychiatrist has been consulted within the last 2 years and has recommended treatment for the patient in writing.

Initial application — (ADHD in patients under 5) only from a paediatrician or psychiatrist. Approvals valid for 12 months for

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

applications meeting the following criteria:

Both:

- 1 ADHD (Attention Deficit and Hyperactivity Disorder) patients under 5 years of age; and
- 2 Diagnosed according to DSM-IV or ICD 10 criteria.

Initial application — (Narcolepsy) only from a neurologist or respiratory specialist. Approvals valid for 24 months where the patient suffers from narcolepsy.

Renewal — (ADHD in patients 5 or over) only from a paediatrician, psychiatrist or medical practitioner on the recommendation of a paediatrician or psychiatrist (in writing). Approvals valid for 24 months for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 Either:
 - 2.1 Applicant is a paediatrician or psychiatrist; or
 - 2.2 Applicant is a medical practitioner and confirms that a paediatrician or psychiatrist has been consulted within the last 2 years and has recommended treatment for the patient in writing.

Renewal — (ADHD in patients under 5) only from a paediatrician or psychiatrist. Approvals valid for 12 months where the treatment remains appropriate and the patient is benefiting from treatment.

Renewal — (Narcolepsy) only from a neurologist or respiratory specialist. Approvals valid for 24 months where the treatment remains appropriate and the patient is benefiting from treatment.

METHYLPHENIDATE HYDROCHLORIDE – Special Authority see [SA1150 below](#) – Retail pharmacy

a) Only on a controlled drug form			
b) Safety medicine; prescriber may determine dispensing frequency			
Tab immediate-release 5 mg.....	3.20	30	✓ Rubifen
Tab immediate-release 10 mg.....	3.00	30	✓ Ritalin
			✓ Rubifen
Tab immediate-release 20 mg.....	7.85	30	✓ Rubifen
Tab sustained-release 20 mg.....	10.95	30	✓ Rubifen SR
	50.00	100	✓ Ritalin SR

►SA1150 Special Authority for Subsidy

Initial application — (ADHD in patients 5 or over) only from a paediatrician, psychiatrist or medical practitioner on the recommendation of a paediatrician or psychiatrist (in writing). Approvals valid for 24 months for applications meeting the following criteria:

All of the following:

- 1 ADHD (Attention Deficit and Hyperactivity Disorder) patients aged 5 years or over; and
- 2 Diagnosed according to DSM-IV or ICD 10 criteria; and
- 3 Either:
 - 3.1 Applicant is a paediatrician or psychiatrist; or
 - 3.2 Applicant is a medical practitioner and confirms that a paediatrician or psychiatrist has been consulted within the last 2 years and has recommended treatment for the patient in writing.

Initial application — (ADHD in patients under 5) only from a paediatrician or psychiatrist. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 ADHD (Attention Deficit and Hyperactivity Disorder) patients under 5 years of age; and
- 2 Diagnosed according to DSM-IV or ICD 10 criteria.

Initial application — (Narcolepsy) only from a neurologist or respiratory specialist. Approvals valid for 24 months where the patient suffers from narcolepsy.

Renewal — (ADHD in patients 5 or over) only from a paediatrician, psychiatrist or medical practitioner on the recommendation of a paediatrician or psychiatrist (in writing). Approvals valid for 24 months for applications meeting the following criteria:

continued...

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 Either:
 - 2.1 Applicant is a paediatrician or psychiatrist; or
 - 2.2 Applicant is a medical practitioner and confirms that a paediatrician or psychiatrist has been consulted within the last 2 years and has recommended treatment for the patient in writing.

Renewal — (ADHD in patients under 5) only from a paediatrician or psychiatrist. Approvals valid for 12 months where the treatment remains appropriate and the patient is benefiting from treatment.

Renewal — (Narcolepsy) only from a neurologist or respiratory specialist. Approvals valid for 24 months where the treatment remains appropriate and the patient is benefiting from treatment.

METHYLPHENIDATE HYDROCHLORIDE EXTENDED-RELEASE – Special Authority see [SA1151 below](#) – Retail pharmacy

a) Only on a controlled drug form			
b) Safety medicine; prescriber may determine dispensing frequency			
Tab extended-release 18 mg.....	58.96	30	✓ Concerta
Tab extended-release 27 mg.....	65.44	30	✓ Concerta
Tab extended-release 36 mg.....	71.93	30	✓ Concerta
Tab extended-release 54 mg.....	86.24	30	✓ Concerta
Cap modified-release 10 mg.....	15.60	30	✓ Ritalin LA
Cap modified-release 20 mg.....	20.40	30	✓ Ritalin LA
Cap modified-release 30 mg.....	25.52	30	✓ Ritalin LA
Cap modified-release 40 mg.....	30.60	30	✓ Ritalin LA

➔SA1151 Special Authority for Subsidy

Initial application only from a paediatrician, psychiatrist or medical practitioner on the recommendation of a paediatrician or psychiatrist (in writing). Approvals valid for 24 months for applications meeting the following criteria:

All of the following:

- 1 ADHD (Attention Deficit and Hyperactivity Disorder); and
- 2 Diagnosed according to DSM-IV or ICD 10 criteria; and
- 3 Either:
 - 3.1 Applicant is a paediatrician or psychiatrist; or
 - 3.2 Applicant is a medical practitioner and confirms that a paediatrician or psychiatrist has been consulted within the last 2 years and has recommended treatment for the patient in writing; and
- 4 Either:
 - 4.1 Patient is taking a currently subsidised formulation of methylphenidate hydrochloride (immediate-release or sustained-release) which has not been effective due to significant administration and/or compliance difficulties; or
 - 4.2 There is significant concern regarding the risk of diversion or abuse of immediate-release methylphenidate hydrochloride.

Renewal only from a paediatrician, psychiatrist or medical practitioner on the recommendation of a paediatrician or psychiatrist (in writing). Approvals valid for 24 months for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 Either:
 - 2.1 Applicant is a paediatrician or psychiatrist; or
 - 2.2 Applicant is a medical practitioner and confirms that a paediatrician or psychiatrist has been consulted within the last 2 years and has recommended treatment for the patient in writing.

MODAFINIL – Special Authority see [SA1126 on the next page](#) – Retail pharmacy

Tab 100 mg.....	72.50	30	✓ Modavigil
-----------------	-------	----	-------------

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
	✓	

►SA1126 Special Authority for Subsidy

Initial application only from a neurologist or respiratory specialist. Approvals valid for 24 months for applications meeting the following criteria:

All of the following:

- 1 The patient has a diagnosis of narcolepsy and has excessive daytime sleepiness associated with narcolepsy occurring almost daily for three months or more; and
- 2 Either:
 - 2.1 The patient has a multiple sleep latency test with a mean sleep latency of less than or equal to 10 minutes and 2 or more sleep onset rapid eye movement periods; or
 - 2.2 The patient has at least one of: cataplexy, sleep paralysis or hypnagogic hallucinations; and
- 3 Either:
 - 3.1 An effective dose of a subsidised formulation of methylphenidate or dexamfetamine has been trialled and discontinued because of intolerable side effects; or
 - 3.2 Methylphenidate and dexamfetamine are contraindicated.

Renewal only from a neurologist or respiratory specialist. Approvals valid for 24 months where the treatment remains appropriate and the patient is benefiting from treatment.

Treatments for Dementia

DONEPEZIL HYDROCHLORIDE

* Tab 5 mg	4.34	90	✓ Donepezil-Rex
* Tab 10 mg	6.64	90	✓ Donepezil-Rex

RIVASTIGMINE – Special Authority see SA1488 below – Retail pharmacy

Patch 4.6 mg per 24 hour	90.00	30	✓ Exelon
Patch 9.5 mg per 24 hour	90.00	30	✓ Exelon

►SA1488 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 The patient has been diagnosed with dementia; and
- 2 The patient has experienced intolerable nausea and/or vomiting from donepezil tablets.

Renewal from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate; and
- 2 The patient has demonstrated a significant and sustained benefit from treatment.

Treatments for Substance Dependence

BUPRENORPHINE WITH NALOXONE – Special Authority see SA1203 below – Retail pharmacy

a) No patient co-payment payable			
b) Safety medicine; prescriber may determine dispensing frequency			
Tab sublingual 2 mg with naloxone 0.5 mg	57.40	28	✓ Suboxone
Tab sublingual 8 mg with naloxone 2 mg	166.00	28	✓ Suboxone

►SA1203 Special Authority for Subsidy

Initial application — (Detoxification) from any medical practitioner. Approvals valid for 1 month for applications meeting the following criteria:

All of the following:

continued...

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
---	-----	--------------------------	-------------------------------------

continued...

- 1 Patient is opioid dependent; and
- 2 Patient is currently engaged with an opioid treatment service approved by the Ministry of Health; and
- 3 Applicant works in an opioid treatment service approved by the Ministry of Health..

Initial application — (Maintenance treatment) from any medical practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient is opioid dependent; and
- 2 Patient will not be receiving methadone; and
- 3 Patient is currently enrolled in an opioid substitution treatment program in a service approved by the Ministry of Health; and
- 4 Applicant works in an opioid treatment service approved by the Ministry of Health.

Renewal — (Detoxification) from any medical practitioner. Approvals valid for 1 month for applications meeting the following criteria:

All of the following:

- 1 Patient is opioid dependent; and
- 2 Patient has previously trialled but failed detoxification with buprenorphine with naloxone with relapse back to opioid use and another attempt is planned; and
- 3 Patient is currently engaged with an opioid treatment service approved by the Ministry of Health; and
- 4 Applicant works in an opioid treatment service approved by the Ministry of Health.

Renewal — (Maintenance treatment) from any medical practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient is or has been receiving maintenance therapy with buprenorphine with naloxone (and is not receiving methadone); and
- 2 Patient is currently enrolled in an opioid substitution program in a service approved by the Ministry of Health; and
- 3 Applicant works in an opioid treatment service approved by the Ministry of Health or is a medical practitioner authorised by the service to manage treatment in this patient.

Renewal — (Maintenance treatment where the patient has previously had an initial application for detoxification) from any medical practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient received but failed detoxification with buprenorphine with naloxone; and
- 2 Maintenance therapy with buprenorphine with naloxone is planned (and patient will not be receiving methadone); and
- 3 Patient is currently enrolled in an opioid substitution program in a service approved by the Ministry of Health; and
- 4 Applicant works in an opioid treatment service approved by the Ministry of Health.

BUPROPION HYDROCHLORIDE

Tab modified-release 150 mg..... 11.00 30 ✓ **Zyban**

DISULFIRAM

Tab 200 mg 44.30 100 ✓ **Antabuse**

NALTREXONE HYDROCHLORIDE – Special Authority see [SA1408](#) below – Retail pharmacy

Tab 50 mg 112.55 30 ✓ **Naltracord**

➔ [SA1408](#) Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Patient is currently enrolled in a recognised comprehensive treatment programme for alcohol dependence; and
- 2 Applicant works in or with a community Alcohol and Drug Service contracted to one of the District Health Boards or accredited against the New Zealand Alcohol and Other Drug Sector Standard or the National Mental Health Sector

continued...

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
--	---	------------------------------	-------------------------------------

continued...

Standard.

Renewal from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Compliance with the medication (prescriber determined); and
- 2 Any of the following:
 - 2.1 Patient is still unstable and requires further treatment; or
 - 2.2 Patient achieved significant improvement but requires further treatment; or
 - 2.3 Patient is well controlled but requires maintenance therapy.

NICOTINE

a) Nicotine will not be funded in amounts less than 4 weeks of treatment.

b) Note: Direct Provision by a pharmacist permitted under the provisions in Part I of Section A.

Patch 7 mg – Up to 28 patch available on a PSO	16.00	28	✓ Habitrol
Patch 7 mg for direct distribution only – [Xpharm]	3.94	7	✓ Habitrol
Patch 14 mg – Up to 28 patch available on a PSO	17.59	28	✓ Habitrol
Patch 14 mg for direct distribution only – [Xpharm]	4.52	7	✓ Habitrol
Patch 21 mg – Up to 28 patch available on a PSO	20.16	28	✓ Habitrol
Patch 21 mg for direct distribution only – [Xpharm]	5.18	7	✓ Habitrol
Lozenge 1 mg – Up to 216 loz available on a PSO	16.61	216	✓ Habitrol
Lozenge 1 mg for direct distribution only – [Xpharm]	3.20	36	✓ Habitrol
Lozenge 2 mg – Up to 216 loz available on a PSO	18.20	216	✓ Habitrol
Lozenge 2 mg for direct distribution only – [Xpharm]	3.24	36	✓ Habitrol
Gum 2 mg (Fruit) – Up to 384 piece available on a PSO	33.69	384	✓ Habitrol
Gum 2 mg (Fruit) for direct distribution only – [Xpharm]	8.64	96	✓ Habitrol
Gum 2 mg (Mint) – Up to 384 piece available on a PSO	33.69	384	✓ Habitrol
Gum 2 mg (Mint) for direct distribution only – [Xpharm]	8.64	96	✓ Habitrol
Gum 4 mg (Fruit) – Up to 384 piece available on a PSO	38.95	384	✓ Habitrol
Gum 4 mg (Fruit) for direct distribution only – [Xpharm]	10.01	96	✓ Habitrol
Gum 4 mg (Mint) – Up to 384 piece available on a PSO	38.95	384	✓ Habitrol
Gum 4 mg (Mint) for direct distribution only – [Xpharm]	10.01	96	✓ Habitrol

VARENICLINE TARTRATE – Special Authority see [SA1575 below](#) – Retail pharmacy

a) Varenicline will not be funded in amounts less than 2 weeks of treatment.

b) A maximum of 12 weeks' varenicline will be subsidised on each Special Authority approval, including the starter pack

Tab 1 mg	67.74	28	✓ Champix
	135.48	56	✓ Champix
Tab 0.5 mg x 11 and 1 mg x 14	60.48	25 OP	✓ Champix

► **SA1575** Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 5 months for applications meeting the following criteria:

All of the following:

- 1 Short-term therapy as an aid to achieving abstinence in a patient who has indicated that they are ready to cease smoking; and
- 2 The patient is part of, or is about to enrol in, a comprehensive support and counselling smoking cessation programme, which includes prescriber or nurse monitoring; and
- 3 Either:
 - 3.1 The patient has tried but failed to quit smoking after at least two separate trials of nicotine replacement therapy, at least one of which included the patient receiving comprehensive advice on the optimal use of nicotine replacement therapy; or

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

- 3.2 The patient has tried but failed to quit smoking using bupropion or nortriptyline; and
- 4 The patient has not used funded varenicline in the last 12 months; and
- 5 Varenicline is not to be used in combination with other pharmacological smoking cessation treatments and the patient has agreed to this; and
- 6 The patient is not pregnant; and
- 7 The patient will not be prescribed more than 12 weeks' funded varenicline (see note).

Renewal from any relevant practitioner. Approvals valid for 5 months for applications meeting the following criteria:
All of the following:

- 1 Short-term therapy as an aid to achieving abstinence in a patient who has indicated that they are ready to cease smoking; and
- 2 The patient is part of, or is about to enrol in, a comprehensive support and counselling smoking cessation programme, which includes prescriber or nurse monitoring; and
- 3 The patient has not used funded varenicline in the last 12 months; and
- 4 Varenicline is not to be used in combination with other pharmacological smoking cessation treatments and the patient has agreed to this; and
- 5 The patient is not pregnant; and
- 6 The patient will not be prescribed more than 12 weeks' funded varenicline (see note).

The patient must not have had an approval in the past 12 months.
Notes: a maximum of 12 weeks' varenicline will be subsidised on each Special Authority approval.
This includes the 2-week 'starter' pack.

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

Chemotherapeutic Agents

Alkylating Agents

BENDAMUSTINE HYDROCHLORIDE – PCT only – Specialist – Special Authority see [SA1667 below](#)

Inj 25 mg vial	271.35	1	✓ Ribomustin
Inj 100 mg vial	1,085.38	1	✓ Ribomustin
Inj 1 mg for ECP	11.40	1 mg	✓ Baxter

►SA1667 Special Authority for Subsidy

Initial application — (treatment naive CLL) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient has Binet stage B or C, or progressive stage A chronic lymphocytic leukaemia requiring treatment; and
- 2 The patient is chemotherapy treatment naive; and
- 3 The patient is unable to tolerate toxicity of full-dose FCR; and
- 4 Patient has ECOG performance status 0-2; and
- 5 Patient has a Cumulative Illness Rating Scale (CIRS) score of < 6; and
- 6 Bendamustine is to be administered at a maximum dose of 100 mg/m² on days 1 and 2 every 4 weeks for a maximum of 6 cycles.

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL). Chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments.

Initial application — (Indolent, Low-grade lymphomas) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 9 months for applications meeting the following criteria:

All of the following:

- 1 The patient has indolent low grade NHL requiring treatment; and
- 2 Patient has a WHO performance status of 0-2; and
- 3 Either:
 - 3.1 Both:
 - 3.1.1 Patient is treatment naive; and
 - 3.1.2 Bendamustine is to be administered for a maximum of 6 cycles (in combination with rituximab when CD20+); or
 - 3.2 All of the following:
 - 3.2.1 Patient has relapsed refractory disease following prior chemotherapy; and
 - 3.2.2 The patient has not received prior bendamustine therapy; and
 - 3.2.3 Either:
 - 3.2.3.1 Both:
 - 3.2.3.1.1 Bendamustine is to be administered for a maximum of 6 cycles in relapsed patients (in combination with rituximab when CD20+); and
 - 3.2.3.1.2 Patient has had a rituximab treatment-free interval of 12 months or more; or
 - 3.2.3.2 Bendamustine is to be administered as a monotherapy for a maximum of 6 cycles in rituximab refractory patients.

Renewal — (Indolent, Low-grade lymphomas) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 9 months for applications meeting the following criteria:

Both:

- 1 Patients have not received a bendamustine regimen within the last 12 months; and
- 2 Either:
 - 2.1 Both:

continued...

ONCOLOGY AGENTS AND IMMUNOSUPPRESSANTS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
continued...				
2.1.1 Bendamustine is to be administered for a maximum of 6 cycles in relapsed patients (in combination with rituximab when CD20+); and				
2.1.2 Patient has had a rituximab treatment-free interval of 12 months or more; or				
2.2 Bendamustine is to be administered as a monotherapy for a maximum of 6 cycles in rituximab refractory patients.				
Note: 'indolent, low-grade lymphomas' includes follicular, mantle cell, marginal zone and lymphoplasmacytic/ Waldenstrom's macroglobulinaemia.				
BUSULFAN – PCT – Retail pharmacy-Specialist				
Tab 2 mg	89.25	100	✓	Myleran
CARBOPLATIN – PCT only – Specialist				
Inj 10 mg per ml, 5 ml vial.....	15.07	1	✓	DBL Carboplatin
	20.00		✓	Carboplatin Ebewe
Inj 10 mg per ml, 15 ml vial.....	14.05	1	✓	DBL Carboplatin
	19.50		✓	Carbaccord
	22.50		✓	Carboplatin Ebewe
Inj 10 mg per ml, 45 ml vial.....	32.59	1	✓	DBL Carboplatin
	48.50		✓	Carbaccord
	50.00		✓	Carboplatin Ebewe
Inj 1 mg for ECP	0.08	1 mg	✓	Baxter
(DBL Carboplatin Inj 10 mg per ml, 5 ml vial to be delisted 1 March 2019)				
(Carboplatin Ebewe Inj 10 mg per ml, 5 ml vial to be delisted 1 March 2019)				
(DBL Carboplatin Inj 10 mg per ml, 15 ml vial to be delisted 1 March 2019)				
(Carbaccord Inj 10 mg per ml, 15 ml vial to be delisted 1 March 2019)				
(Carboplatin Ebewe Inj 10 mg per ml, 15 ml vial to be delisted 1 March 2019)				
CARMUSTINE – PCT only – Specialist				
Inj 100 mg vial	532.00	1	✓	BiCNU
Inj 100 mg for ECP	532.00	100 mg OP	✓	Baxter
CHLORAMBUCIL – PCT – Retail pharmacy-Specialist				
Tab 2 mg	29.06	25	✓	Leukeran FC
CISPLATIN – PCT only – Specialist				
Inj 1 mg per ml, 50 ml vial.....	12.29	1	✓	DBL Cisplatin
	15.00		✓	Cisplatin Ebewe
Inj 1 mg per ml, 100 ml vial.....	19.70	1	✓	DBL Cisplatin
	21.00		✓	Cisplatin Ebewe
Inj 1 mg for ECP	0.25	1 mg	✓	Baxter
CYCLOPHOSPHAMIDE				
Tab 50 mg – PCT – Retail pharmacy-Specialist.....	79.00	50	✓	Endoxan ^{\$29}
	158.00	100	✓	Procytox ^{\$29}
Wastage claimable				
Inj 1 g vial – PCT – Retail pharmacy-Specialist.....	35.65	1	✓	Endoxan
	127.80	6	✓	Cytoxan
Inj 2 g vial – PCT only – Specialist.....	71.25	1	✓	Endoxan
Inj 1 mg for ECP – PCT only – Specialist.....	0.04	1 mg	✓	Baxter
IFOSFAMIDE – PCT only – Specialist				
Inj 1 g.....	96.00	1	✓	Holoxan
Inj 2 g.....	180.00	1	✓	Holoxan
Inj 1 mg for ECP	0.10	1 mg	✓	Baxter
LOMUSTINE – PCT – Retail pharmacy-Specialist				
Cap 10 mg.....	132.59	20	✓	CeeNU
Cap 40 mg.....	399.15	20	✓	CeeNU

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
MELPHALAN				
Tab 2 mg – PCT – Retail pharmacy-Specialist.....	40.70	25	✓	Alkeran
Inj 50 mg – PCT only – Specialist.....	67.80	1	✓	Alkeran
OXALIPLATIN – PCT only – Specialist				
Inj 5 mg per ml, 10 ml vial.....	13.32	1	✓	Oxaliccord
Inj 50 mg vial	15.32	1	✓	Oxaliplatin Actavis 50
	55.00		✓	Oxaliplatin Ebewe
Inj 100 mg vial	25.01	1	✓	Oxaliplatin Actavis 100
	110.00		✓	Oxaliplatin Ebewe
Inj 5 mg per ml, 20 ml vial.....	46.32	1	✓	Oxaliccord
Inj 1 mg for ECP	0.18	1 mg	✓	Baxter
<i>(Oxaliccord Inj 5 mg per ml, 10 ml vial to be delisted 1 January 2019)</i>				
<i>(Oxaliplatin Actavis 50 Inj 50 mg vial to be delisted 1 January 2019)</i>				
<i>(Oxaliplatin Ebewe Inj 50 mg vial to be delisted 1 January 2019)</i>				
THIOTEPA – PCT only – Specialist				
Inj 15 mg vial	CBS	1	✓	Bedford ^{\$29}
			✓	THIO-TEPA ^{\$29}
			✓	Tepadina ^{\$29}
Inj 100 mg vial	CBS	1	✓	Tepadina ^{\$29}

Antimetabolites

AZACITIDINE – PCT only – Specialist – Special Authority see SA1467 below

Inj 100 mg vial	139.00	1	✓	Azacitidine Dr Reddy's
	605.00		✓	Vidaza
Inj 1 mg for ECP	6.66	1 mg	✓	Baxter

►SA1467 Special Authority for Subsidy

Initial application only from a haematologist or medical practitioner on the recommendation of a haematologist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- Any of the following:
 - The patient has International Prognostic Scoring System (IPSS) intermediate-2 or high risk myelodysplastic syndrome; or
 - The patient has chronic myelomonocytic leukaemia (10%-29% marrow blasts without myeloproliferative disorder); or
 - The patient has acute myeloid leukaemia with 20-30% blasts and multi-lineage dysplasia, according to World Health Organisation Classification (WHO); and
- The patient has performance status (WHO/ECOG) grade 0-2; and
- The patient does not have secondary myelodysplastic syndrome resulting from chemical injury or prior treatment with chemotherapy and/or radiation for other diseases; and
- The patient has an estimated life expectancy of at least 3 months.

Renewal only from a haematologist or medical practitioner on the recommendation of a haematologist. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- No evidence of disease progression; and
- The treatment remains appropriate and patient is benefitting from treatment.

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

ONCOLOGY AGENTS AND IMMUNOSUPPRESSANTS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
CALCIUM FOLINATE				
Tab 15 mg – PCT – Retail pharmacy-Specialist.....	104.26	10	✓	DBL Leucovorin Calcium
Inj 3 mg per ml, 1 ml – PCT – Retail pharmacy-Specialist	17.10	5	✓	Hospira
Inj 10 mg per ml, 5 ml vial – PCT – Retail pharmacy-Specialist.....	4.55	1	✓	Calcium Folate Sandoz
Inj 50 mg – PCT – Retail pharmacy-Specialist	18.25	5	✓	Calcium Folate Ebewe
Inj 10 mg per ml, 10 ml vial – PCT only – Specialist	7.30	1	✓	Calcium Folate Sandoz
Inj 100 mg – PCT only – Specialist.....	7.33	1	✓	Calcium Folate Ebewe
Inj 300 mg – PCT only – Specialist.....	22.51	1	✓	Calcium Folate Ebewe
Inj 10 mg per ml, 35 ml vial – PCT only – Specialist	20.95	1	✓	Calcium Folate Sandoz
Inj 1 g – PCT only – Specialist.....	67.51	1	✓	Calcium Folate Ebewe
Inj 10 mg per ml, 100 ml vial – PCT only – Specialist	60.00	1	✓	Calcium Folate Sandoz
Inj 1 mg for ECP – PCT only – Specialist.....	0.06	1 mg	✓	Baxter
CAPECITABINE – Retail pharmacy-Specialist				
Tab 150 mg	11.15	60	✓	Brinov
Tab 500 mg	62.28	120	✓	Brinov
CLADRIBINE – PCT only – Specialist				
Inj 1 mg per ml, 10 ml.....	5,249.72	7	✓	Leustatin
Inj 10 mg for ECP	749.96	10 mg OP	✓	Baxter
CYTARABINE				
Inj 20 mg per ml, 5 ml vial – PCT – Retail pharmacy-Specialist.....	400.00	5	✓	Pfizer
Inj 100 mg per ml, 20 ml vial – PCT – Retail pharmacy-Specialist	41.36	1	✓	Pfizer
Inj 1 mg for ECP – PCT only – Specialist.....	0.25	10 mg	✓	Baxter
Inj 100 mg intrathecal syringe for ECP – PCT only – Specialist.....	80.00	100 mg OP	✓	Baxter
FLUDARABINE PHOSPHATE				
Tab 10 mg – PCT – Retail pharmacy-Specialist.....	412.00	20	✓	Fludara Oral
Inj 50 mg vial – PCT only – Specialist	525.00	5	✓	Fludarabine Ebewe
Inj 50 mg for ECP – PCT only – Specialist.....	105.00	50 mg OP	✓	Baxter
FLUOROURACIL				
Inj 50 mg per ml, 20 ml vial – PCT only – Specialist	12.00	1	✓	Fluorouracil Ebewe
Inj 50 mg per ml, 50 ml vial – PCT only – Specialist	17.00	1	✓	Fluorouracil Ebewe
Inj 50 mg per ml, 100 ml vial – PCT only – Specialist	30.00	1	✓	Fluorouracil Ebewe
Inj 1 mg for ECP – PCT only – Specialist.....	0.66	100 mg	✓	Baxter
<i>(Fluorouracil Ebewe Inj 50 mg per ml, 50 ml vial to be delisted 1 March 2019)</i>				
GEMCITABINE HYDROCHLORIDE – PCT only – Specialist				
Inj 1 g, 26.3 ml vial.....	62.50	1	✓	DBL Gemcitabine
Inj 1 g.....	15.89	1	✓	Gemcitabine Ebewe
	349.20		✓	Gemzar
Inj 200 mg.....	8.36	1	✓	Gemcitabine Ebewe
	78.00		✓	Gemzar
Inj 1 mg for ECP.....	0.02	1 mg	✓	Baxter

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
IRINOTECAN HYDROCHLORIDE – PCT only – Specialist				
Inj 20 mg per ml, 2 ml vial.....	11.50	1	✓	Irinotecan Actavis 40
	41.00		✓	Camptosar
			✓	Irinotecan-Rex
Inj 20 mg per ml, 5 ml vial.....	17.80	1	✓	Irinotecan Actavis 100
	100.00		✓	Camptosar
			✓	Irinotecan-Rex
Inj 1 mg for ECP	0.19	1 mg	✓	Baxter
MERCAPTOPURINE				
Tab 50 mg – PCT – Retail pharmacy-Specialist.....	49.41	25	✓	Puri-nethol
Oral suspension 20 mg per ml – Retail pharmacy-Specialist – Special Authority see SA1725 below	428.00	100 ml OP	✓	Allmercap
➡SA1725 Special Authority for Subsidy				
Initial application only from a paediatric haematologist or paediatric oncologist. Approvals valid for 12 months where the patient requires a total dose of less than one full 50 mg tablet per day.				
Renewal only from a paediatric haematologist or paediatric oncologist. Approvals valid for 12 months where patient still requires a total dose of less than one full 50 mg tablet per day.				
METHOTREXATE				
* Tab 2.5 mg – PCT – Retail pharmacy-Specialist.....	3.18	30	✓	Trexate
	8.05	90	✓	Trexate
* Tab 10 mg – PCT – Retail pharmacy-Specialist.....	21.00	50	✓	Trexate
	31.75	90	✓	Trexate
* Inj 2.5 mg per ml, 2 ml – PCT – Retail pharmacy-Specialist	47.50	5	✓	Hospira
* Inj 7.5 mg prefilled syringe.....	14.61	1	✓	Methotrexate Sandoz
* Inj 10 mg prefilled syringe.....	14.66	1	✓	Methotrexate Sandoz
* Inj 15 mg prefilled syringe.....	14.77	1	✓	Methotrexate Sandoz
* Inj 20 mg prefilled syringe.....	14.88	1	✓	Methotrexate Sandoz
* Inj 25 mg prefilled syringe.....	14.99	1	✓	Methotrexate Sandoz
* Inj 30 mg prefilled syringe.....	15.09	1	✓	Methotrexate Sandoz
* Inj 25 mg per ml, 2 ml vial – PCT – Retail pharmacy-Specialist.....	30.00	5	✓	DBL Methotrexate Onco-Vial
* Inj 25 mg per ml, 20 ml vial – PCT – Retail pharmacy-Specialist.....	45.00	1	✓	DBL Methotrexate Onco-Vial
* Inj 100 mg per ml, 10 ml – PCT – Retail pharmacy-Specialist	25.00	1	✓	Methotrexate Ebewe
* Inj 100 mg per ml, 50 ml vial – PCT – Retail pharmacy-Specialist	79.99	1	✓	Methotrexate Ebewe
* Inj 1 mg for ECP – PCT only – Specialist	0.06	1 mg	✓	Baxter
* Inj 5 mg intrathecal syringe for ECP – PCT only – Specialist.....	4.73	5 mg OP	✓	Baxter
PEMETREXED – PCT only – Specialist – Special Authority see SA1679 on the next page				
Inj 100 mg vial	60.89	1	✓	Juno Pemetrexed
Inj 500 mg vial	217.77	1	✓	Juno Pemetrexed
Inj 1 mg for ECP	0.55	1 mg	✓	Baxter

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

►SA1679 Special Authority for Subsidy

Initial application — (mesothelioma) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 8 months for applications meeting the following criteria:

Both:

- 1 Patient has been diagnosed with mesothelioma; and
- 2 Pemetrexed to be administered at a dose of 500 mg/m² every 21 days in combination with cisplatin or carboplatin for a maximum of 6 cycles.

Renewal — (mesothelioma) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 8 months for applications meeting the following criteria:

All of the following:

- 1 No evidence of disease progression; and
- 2 The treatment remains appropriate and the patient is benefitting from treatment; and
- 3 Pemetrexed to be administered at a dose of 500mg/m² every 21 days for a maximum of 6 cycles.

Initial application — (non-small cell lung carcinoma) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 8 months for applications meeting the following criteria:

Both:

- 1 Patient has locally advanced or metastatic non-squamous non-small cell lung carcinoma; and
- 2 Either:
 - 2.1 Both:
 - 2.1.1 Patient has chemotherapy-naïve disease; and
 - 2.1.2 Pemetrexed is to be administered at a dose of 500 mg/m² every 21 days in combination with cisplatin or carboplatin for a maximum of 6 cycles; or
 - 2.2 All of the following:
 - 2.2.1 Patient has had first-line treatment with platinum based chemotherapy; and
 - 2.2.2 Patient has not received prior funded treatment with pemetrexed; and
 - 2.2.3 Pemetrexed is to be administered at a dose of 500 mg/m² every 21 days for a maximum of 6 cycles.

Renewal — (non-small cell lung carcinoma) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 8 months for applications meeting the following criteria:

All of the following:

- 1 No evidence of disease progression; and
- 2 The treatment remains appropriate and the patient is benefitting from treatment; and
- 3 Pemetrexed is to be administered at a dose of 500mg/m² every 21 days.

THIOGUANINE – PCT – Retail pharmacy-Specialist

Tab 40 mg	126.31	25	✓ Lanvis
-----------------	--------	----	----------

Other Cytotoxic Agents

AMSACRINE – PCT only – Specialist

Inj 50 mg per ml, 1.5 ml ampoule	1,500.00	6	✓ Amsidine ^{\$29}
Inj 75 mg	1,250.00	5	✓ AmsaLyo ^{\$29}

ANAGRELIDE HYDROCHLORIDE – PCT – Retail pharmacy-Specialist

Cap 0.5 mg	CBS	100	✓ Agrylin ^{\$29} ✓ Teva ^{\$29}
------------------	-----	-----	---

ARSENIC TRIOXIDE – PCT only – Specialist

Inj 10 mg	4,817.00	10	✓ AFT ^{\$29}
-----------------	----------	----	-----------------------

BLEOMYCIN SULPHATE – PCT only – Specialist

Inj 15,000 iu, vial	161.01	1	✓ DBL Bleomycin Sulfate
Inj 1,000 iu for ECP	12.45	1,000 iu	✓ Baxter

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
BORTEZOMIB – PCT only – Specialist – Special Authority see SA1576 below				
Inj 3.5 mg vial	1,892.50	1	✓	Velcade
Inj 1 mg for ECP	594.77	1 mg	✓	Baxter
►SA1576 Special Authority for Subsidy				
Initial application — (Treatment naive multiple myeloma/amyloidosis) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 2 years for applications meeting the following criteria:				
Both:				
1 Either:				
1.1 The patient has treatment-naive symptomatic multiple myeloma; or				
1.2 The patient has treatment-naive symptomatic systemic AL amyloidosis *; and				
2 Maximum of 9 treatment cycles.				
Note: Indications marked with * are unapproved indications.				
Initial application — (Relapsed/refractory multiple myeloma/amyloidosis) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 8 months for applications meeting the following criteria:				
All of the following:				
1 Either:				
1.1 The patient has relapsed or refractory multiple myeloma; or				
1.2 The patient has relapsed or refractory systemic AL amyloidosis *; and				
2 The patient has received only one prior front line chemotherapy for multiple myeloma or amyloidosis; and				
3 The patient has not had prior publicly funded treatment with bortezomib; and				
4 Maximum of 4 treatment cycles.				
Note: Indications marked with * are unapproved indications.				
Renewal — (Relapsed/refractory multiple myeloma/amyloidosis) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 8 months for applications meeting the following criteria:				
Both:				
1 The patient's disease obtained at least a partial response from treatment with bortezomib at the completion of cycle 4; and				
2 Maximum of 4 further treatment cycles (making a total maximum of 8 consecutive treatment cycles).				
Notes: Responding relapsed/refractory multiple myeloma patients should receive no more than 2 additional cycles of treatment beyond the cycle at which a confirmed complete response was first achieved. A line of therapy is considered to comprise either:				
a) a known therapeutic chemotherapy regimen and supportive treatments; or				
b) a transplant induction chemotherapy regimen, stem cell transplantation and supportive treatments.				
Refer to datasheet for recommended dosage and number of doses of bortezomib per treatment cycle.				
COLASPASE [L-ASPARAGINASE] – PCT only – Specialist				
Inj 10,000 iu	102.32	1	✓	Leunase
Inj 10,000 iu for ECP	102.32	10,000 iu OP	✓	Baxter
DACARBAZINE – PCT only – Specialist				
Inj 200 mg vial	58.06	1	✓	DBL Dacarbazine
	580.60	10	✓	Dacarbazine
				APP S29
Inj 200 mg for ECP	58.06	200 mg OP	✓	Baxter
DACTINOMYCIN [ACTINOMYCIN D] – PCT only – Specialist				
Inj 0.5 mg vial	166.75	1	✓	Cosmegen
Inj 0.5 mg for ECP	166.75	0.5 mg OP	✓	Baxter
DAUNORUBICIN – PCT only – Specialist				
Inj 2 mg per ml, 10 ml	130.00	1	✓	Pfizer
Inj 20 mg for ECP	130.00	20 mg OP	✓	Baxter

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

ONCOLOGY AGENTS AND IMMUNOSUPPRESSANTS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
DOCETAXEL – PCT only – Specialist				
Inj 10 mg per ml, 2 ml vial.....	12.40	1	✓	DBL Docetaxel
Inj 20 mg.....	48.75	1	✓	Docetaxel Sandoz
Inj 10 mg per ml, 8 ml vial.....	26.95	1	✓	DBL Docetaxel
Inj 80 mg.....	195.00	1	✓	Docetaxel Sandoz
Inj 1 mg for ECP.....	0.55	1 mg	✓	Baxter
DOXORUBICIN HYDROCHLORIDE – PCT only – Specialist				
Inj 2 mg per ml, 5 ml vial.....	10.00	1	✓	Doxorubicin Ebewe
Inj 2 mg per ml, 25 ml vial.....	11.50	1	✓	Doxorubicin Ebewe
	17.00		✓	Arrow-Doxorubicin
Inj 2 mg per ml, 50 ml vial.....	23.00	1	✓	Doxorubicin Ebewe
Inj 2 mg per ml, 100 ml vial.....	56.15	1	✓	Doxorubicin Ebewe
	65.00		✓	Arrow-Doxorubicin
Inj 1 mg for ECP.....	0.25	1 mg	✓	Baxter
EPIRUBICIN HYDROCHLORIDE – PCT only – Specialist				
Inj 2 mg per ml, 5 ml vial.....	25.00	1	✓	Epirubicin Ebewe
Inj 2 mg per ml, 25 ml vial.....	30.00	1	✓	Epirubicin Ebewe
Inj 2 mg per ml, 50 ml vial.....	32.50	1	✓	Epirubicin Ebewe
Inj 2 mg per ml, 100 ml vial.....	65.00	1	✓	Epirubicin Ebewe
Inj 1 mg for ECP.....	0.36	1 mg	✓	Baxter
ETOPOSIDE				
Cap 50 mg – PCT – Retail pharmacy-Specialist.....	340.73	20	✓	Vepesid
Cap 100 mg – PCT – Retail pharmacy-Specialist.....	340.73	10	✓	Vepesid
Inj 20 mg per ml, 5 ml vial – PCT – Retail pharmacy-Specialist.....	7.90	1	✓	Rex Medical
Inj 1 mg for ECP – PCT only – Specialist.....	0.09	1 mg	✓	Baxter
ETOPOSIDE PHOSPHATE – PCT only – Specialist				
Inj 100 mg (of etoposide base).....	40.00	1	✓	Etopophos
Inj 1 mg (of etoposide base) for ECP.....	0.47	1 mg	✓	Baxter
HYDROXYUREA – PCT – Retail pharmacy-Specialist				
Cap 500 mg.....	31.76	100	✓	Hydrea
IDARUBICIN HYDROCHLORIDE				
Inj 5 mg vial – PCT only – Specialist.....	93.00	1	✓	Zavedos
Inj 10 mg vial – PCT only – Specialist.....	198.00	1	✓	Zavedos
Inj 1 mg for ECP – PCT only – Specialist.....	21.84	1 mg	✓	Baxter
LENALIDOMIDE – Retail pharmacy-Specialist – Special Authority see SA1468 below				
Wastage claimable				
Cap 10 mg.....	6,207.00	21	✓	Revlimid
Cap 15 mg.....	7,239.18	21	✓	Revlimid
Cap 25 mg.....	7,627.00	21	✓	Revlimid

►SA1468 Special Authority for Subsidy

Initial application — (Relapsed/refractory disease) only from a haematologist or medical practitioner on the recommendation of a haematologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has relapsed or refractory multiple myeloma with progressive disease; and
- 2 Either:
 - 2.1 Lenalidomide to be used as third line* treatment for multiple myeloma; or
 - 2.2 Both:

continued...

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
--	---	------------------------------	-------------------------------------

continued...

2.2.1 Lenalidomide to be used as second line treatment for multiple myeloma; and

2.2.2 The patient has experienced severe (grade 3 or higher), dose limiting, peripheral neuropathy with either bortezomib or thalidomide that precludes further treatment with either of these treatments; and

3 Lenalidomide to be administered at a maximum dose of 25 mg/day in combination with dexamethasone.

Renewal only from a haematologist or medical practitioner on the recommendation of a haematologist. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 No evidence of disease progression; and
- 2 The treatment remains appropriate and patient is benefitting from treatment.

Note: Indication marked with * is an unapproved indication. A line of treatment is considered to comprise either: a) a known therapeutic chemotherapy regimen and supportive treatments or b) a transplant induction chemotherapy regimen, stem cell transplantation and supportive treatments. Prescriptions must be written by a registered prescriber in the lenalidomide risk management programme operated by the supplier.

MESNA

Tab 400 mg – PCT – Retail pharmacy-Specialist.....	273.00	50	✓ Uromitexan
Tab 600 mg – PCT – Retail pharmacy-Specialist.....	407.50	50	✓ Uromitexan
Inj 100 mg per ml, 4 ml ampoule – PCT only – Specialist.....	161.25	15	✓ Uromitexan
Inj 100 mg per ml, 10 ml ampoule – PCT only – Specialist.....	370.35	15	✓ Uromitexan
Inj 1 mg for ECP – PCT only – Specialist.....	2.69	100 mg	✓ Baxter

MITOMYCIN C – PCT only – Specialist

Inj 5 mg vial	204.08	1	✓ Arrow
Inj 1 mg for ECP	42.04	1 mg	✓ Baxter

MITOZANTRONE – PCT only – Specialist

Inj 2 mg per ml, 10 ml vial.....	97.50	1	✓ Mitozantrone Ebewe
Inj 1 mg for ECP	5.51	1 mg	✓ Baxter

PACLITAXEL – PCT only – Specialist

Inj 30 mg.....	47.30	5	✓ Paclitaxel Ebewe
Inj 100 mg.....	20.00	1	✓ Paclitaxel Ebewe
	91.67		✓ Paclitaxel Actavis
Inj 150 mg.....	26.69	1	✓ Paclitaxel Ebewe
	137.50		✓ Anzatax
			✓ Paclitaxel Actavis
Inj 300 mg.....	35.35	1	✓ Paclitaxel Ebewe
	275.00		✓ Anzatax
			✓ Paclitaxel Actavis
Inj 1 mg for ECP	0.19	1 mg	✓ Baxter

PEGASPARGASE – PCT only – Special Authority see SA1325 below

Inj 3,750 IU per 5 ml	3,005.00	1	✓ Oncaspar \$29
-----------------------------	----------	---	-----------------

➡SA1325 Special Authority for Subsidy

Initial application only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist.

Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient has newly diagnosed acute lymphoblastic leukaemia; and
- 2 Pegaspargase to be used with a contemporary intensive multi-agent chemotherapy treatment protocol; and
- 3 Treatment is with curative intent.

Renewal only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid

continued...

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient has relapsed acute lymphoblastic leukaemia; and
- 2 Pegaspargase to be used with a contemporary intensive multi-agent chemotherapy treatment protocol; and
- 3 Treatment is with curative intent.

PENTOSTATIN [DEOXYCOFORMYCIN] – PCT only – Specialist

Inj 10 mg.....CBS 1 ✓ **Nipent** \$29

PROCARBAZINE HYDROCHLORIDE – PCT – Retail pharmacy-Specialist

Cap 50 mg.....498.00 50 ✓ **Natulan** \$29

TEMOZOLOMIDE – Special Authority see [SA1741 below](#) – Retail pharmacy

Cap 5 mg.....10.20 5 ✓ **Orion**
Temozolomide

Cap 20 mg.....18.30 5 ✓ **Orion**
Temozolomide

Cap 100 mg.....40.20 5 ✓ **Temizole 20** \$29
Orion
Temozolomide

Cap 140 mg.....56.00 5 ✓ **Orion**
Temozolomide

Cap 250 mg.....96.80 5 ✓ **Orion**
Temozolomide

►[SA1741](#) Special Authority for Subsidy

Initial application — (high grade gliomas) only from a relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Either:
 - 1.1 Patient has newly diagnosed glioblastoma multiforme; or
 - 1.2 Patient has newly diagnosed anaplastic astrocytoma*; and
- 2 Temozolomide is to be (or has been) given concomitantly with radiotherapy; and
- 3 Following concomitant treatment temozolomide is to be used for a maximum of 5 days treatment per cycle, at a maximum dose of 200 mg/m² per day.

Initial application — (neuroendocrine tumours) only from a relevant specialist. Approvals valid for 9 months for applications meeting the following criteria:

All of the following:

- 1 Patient has been diagnosed with metastatic or unresectable well-differentiated neuroendocrine tumour*; and
- 2 Temozolomide is to be given in combination with capecitabine; and
- 3 Temozolomide is to be used in 28 day treatment cycles for a maximum of 5 days treatment per cycle at a maximum dose of 200 mg/m² per day; and
- 4 Temozolomide to be discontinued at disease progression.

Initial application — (ewing's sarcoma) only from a relevant specialist. Approvals valid for 9 months where the patient has relapsed/refractory Ewing's sarcoma.

Renewal — (high grade gliomas) only from a relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

Either:

- 1 Both:

continued...

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
--	---	------------------------------	-------------------------------------

continued...

- 1.1 Patient has glioblastoma multiforme; and
- 1.2 The treatment remains appropriate and the patient is benefitting from treatment; or
- 2 All of the following:
 - 2.1 Patient has anaplastic astrocytoma*; and
 - 2.2 The treatment remains appropriate and the patient is benefitting from treatment; and
 - 2.3 Adjuvant temozolomide is to be used for a maximum of 24 months.

Renewal — (neuroendocrine tumours) only from a relevant specialist. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 No evidence of disease progression; and
- 2 The treatment remains appropriate and the patient is benefitting from treatment.

Renewal — (ewing's sarcoma) only from a relevant specialist. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 No evidence of disease progression; and
- 2 The treatment remains appropriate and the patient is benefitting from treatment.

Note: Indication marked with a * is an unapproved indication. Temozolomide is not subsidised for the treatment of relapsed high grade glioma.

THALIDOMIDE – Retail pharmacy-Specialist – Special Authority see [SA1124 below](#)

Cap 50 mg.....	378.00	28	✓ Thalomid
Cap 100 mg.....	756.00	28	✓ Thalomid

►SA1124 Special Authority for Subsidy

Initial application only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist.

Approvals valid for 12 months for applications meeting the following criteria:

Either:

- 1 The patient has multiple myeloma; or
- 2 The patient has systemic AL amyloidosis*.

Renewal only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid without further renewal unless notified where the patient has obtained a response from treatment during the initial approval period.

Notes: Prescription must be written by a registered prescriber in the thalidomide risk management programme operated by the supplier.

Maximum dose of 400 mg daily as monotherapy or in a combination therapy regimen.

Indication marked with * is an unapproved indication.

TRETINOIN

Cap 10 mg – PCT – Retail pharmacy-Specialist.....	479.50	100	✓ Vesanoid
---	--------	-----	-------------------

VINBLASTINE SULPHATE

Inj 1 mg per ml, 10 ml vial – PCT – Retail pharmacy-Specialist.....	186.46	5	✓ Hospira
Inj 1 mg for ECP – PCT only – Specialist.....	4.14	1 mg	✓ Baxter

VINCISTINE SULPHATE

Inj 1 mg per ml, 1 ml vial – PCT – Retail pharmacy-Specialist.....	74.52	5	✓ DBL Vincristine Sulfate
Inj 1 mg per ml, 2 ml vial – PCT – Retail pharmacy-Specialist.....	85.61	5	✓ DBL Vincristine Sulfate
Inj 1 mg for ECP – PCT only – Specialist.....	11.30	1 mg	✓ Baxter

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
VINORELBINE – PCT only – Specialist				
Inj 10 mg per ml, 1 ml vial.....	8.00	1	✓	Navelbine
	42.00		✓	Vinorelbine Ebewe
Inj 10 mg per ml, 5 ml vial.....	40.00	1	✓	Navelbine
	210.00		✓	Vinorelbine Ebewe
Inj 1 mg for ECP.....	0.90	1 mg	✓	Baxter

Protein-tyrosine Kinase Inhibitors

DASATINIB – Special Authority see [SA0976 below](#) – [Xpharm]

Tab 20 mg	3,774.06	60	✓	Sprycel
Tab 50 mg	6,214.20	60	✓	Sprycel
Tab 70 mg	7,692.58	60	✓	Sprycel
Tab 100 mg	6,214.20	30	✓	Sprycel

► [SA0976](#) Special Authority for Subsidy

Special Authority approved by the CML/GIST Co-ordinator

Notes: Application details may be obtained from PHARMAC's website <http://www.pharmac.govt.nz>, and prescriptions should be sent to:

The CML/GIST Co-ordinator Phone: (04) 460 4990
 PHARMAC Facsimile: (04) 916 7571
 PO Box 10 254 Email: cmlgistcoordinator@pharmac.govt.nz
 Wellington

Special Authority criteria for CML - access by application

- Funded for patients with diagnosis (confirmed by a haematologist) of a chronic myeloid leukaemia (CML) in blast crisis, accelerated phase, or in chronic phase.
- Maximum dose of 140 mg/day for accelerated or blast phase, and 100 mg/day for chronic phase CML.
- Subsidised for use as monotherapy only.
- Initial approvals valid seven months.
- Subsequent approval(s) are granted on application and are valid for six months. The first reapplication (after seven months) should provide details of the haematological response. The third reapplication should provide details of the cytogenetic response after 14-18 months from initiating therapy. All other reapplications should provide details of haematological response, and cytogenetic response if such data is available. Applications to be made and subsequent prescriptions can be written by a haematologist or an oncologist.

Note: Dasatinib is indicated for the treatment of adults with chronic, accelerated or blast phase CML with resistance or intolerance to prior therapy including imatinib.

Guideline on discontinuation of treatment for patients with CML

- Prescribers should consider discontinuation of treatment if, after 6 months from initiating therapy, a patient did not obtain a haematological response as defined as any one of the following three levels of response:
 - complete haematologic response (as characterised by an absolute neutrophil count (ANC) $> 1.5 \times 10^9/L$, platelets $> 100 \times 10^9/L$, absence of peripheral blood (PB) blasts, bone marrow (BM) blasts $< 5\%$ (or FISH Ph+ 0-35% metaphases), and absence of extramedullary disease); or
 - no evidence of leukaemia (as characterised by an absolute neutrophil count (ANC) $> 1.0 \times 10^9/L$, platelets $> 20 \times 10^9/L$, absence of peripheral blood (PB) blasts, bone marrow (BM) blasts $< 5\%$ (or FISH Ph+ 0-35% metaphases), and absence of extramedullary disease); or
 - return to chronic phase (as characterised by BM and PB blasts $< 15\%$, BM and PB blasts and promyelocytes $< 30\%$, PB basophils $< 20\%$ and absence of extramedullary disease other than spleen and liver).
- Prescribers should consider discontinuation of treatment if, after 18 months from initiating therapy, a patient did not obtain a major cytogenetic response defined as 0-35% Ph+ metaphases.

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
ERLOTINIB – Retail pharmacy-Specialist – Special Authority see SA1653 below				
Tab 100 mg	764.00	30	✓	Tarceva
Tab 150 mg	1,146.00	30	✓	Tarceva

► **SA1653 Special Authority for Subsidy**

Initial application only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist.

Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Patient has locally advanced or metastatic, unresectable, non-squamous Non Small Cell Lung Cancer (NSCLC); and
- 2 There is documentation confirming that the disease expresses activating mutations of EGFR tyrosine kinase; and
- 3 Either:
 - 3.1 Patient is treatment naive; or
 - 3.2 Both:
 - 3.2.1 The patient has discontinued gefitinib due to intolerance; and
 - 3.2.2 The cancer did not progress while on gefitinib; and
- 4 Erlotinib is to be given for a maximum of 3 months.

Renewal only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months where radiological assessment (preferably including CT scan) indicates NSCLC has not progressed.

GEFITINIB – Retail pharmacy-Specialist – Special Authority see [SA1654 below](#)

Tab 250 mg	1,700.00	30	✓	Iressa
------------------	----------	----	---	---------------

► **SA1654 Special Authority for Subsidy**

Initial application only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist.

Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Patient has locally advanced, or metastatic, unresectable, non-squamous Non Small Cell Lung Cancer (NSCLC); and
- 2 Either:
 - 2.1 Patient is treatment naive; or
 - 2.2 Both:
 - 2.2.1 The patient has discontinued erlotinib due to intolerance; and
 - 2.2.2 The cancer did not progress whilst on erlotinib; and
- 3 There is documentation confirming that disease expresses activating mutations of EGFR tyrosine kinase; and
- 4 Gefitinib is to be given for a maximum of 3 months.

Renewal only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months where radiological assessment (preferably including CT scan) indicates NSCLC has not progressed.

IMATINIB MESILATE

Note: Imatinib-AFT is not a registered for the treatment of Gastro Intestinal Stromal Tumours (GIST). The Glivec brand of imatinib mesilate (supplied by Novartis) remains fully subsidised under Special Authority for patients with unresectable and/or metastatic malignant GIST, see SA1460 in Section B of the Pharmaceutical Schedule.

Tab 100 mg – Special Authority see [SA1460 below](#) –

[Xpharm]	2,400.00	60	✓	Glivec
* Cap 100 mg	98.00	60	✓	Imatinib-AFT
* Cap 400 mg	197.50	30	✓	Imatinib-AFT

► **SA1460 Special Authority for Subsidy**

Special Authority approved by the CML/GIST Co-ordinator

Notes: Application details may be obtained from PHARMAC's website <http://www.pharmac.govt.nz>, and prescriptions should be sent to:

continued...

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

The CML/GIST Co-ordinator Phone: (04) 460 4990
 PHARMAC Facsimile: (04) 916 7571
 PO Box 10 254 Email: cmlgistcoordinator@pharmac.govt.nz
 Wellington

Special Authority criteria for GIST – access by application

Funded for patients:

- With a diagnosis (confirmed by an oncologist) of unresectable and/or metastatic malignant gastrointestinal stromal tumour (GIST).
- Maximum dose of 400 mg/day.
- Applications to be made and subsequent prescriptions can be written by an oncologist.
- Initial and subsequent applications are valid for one year. The re-application criterion is an adequate clinical response to the treatment with imatinib (prescriber determined).

LAPATINIB DITOSYLATE – Special Authority see [SA1191 below](#) – Retail pharmacy

Tab 250 mg	1,899.00	70	✓ Tykerb
------------------	----------	----	----------

►SA1191 Special Authority for Subsidy

Initial application — (metastatic breast cancer) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

Either:

- All of the following:
 - The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology); and
 - The patient has not previously received trastuzumab treatment for HER 2 positive metastatic breast cancer; and
 - Lapatinib not to be given in combination with trastuzumab; and
 - Lapatinib to be discontinued at disease progression; or
- All of the following:
 - The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology); and
 - The patient started trastuzumab for metastatic breast cancer but discontinued trastuzumab within 3 months of starting treatment due to intolerance; and
 - The cancer did not progress whilst on trastuzumab; and
 - Lapatinib not to be given in combination with trastuzumab; and
 - Lapatinib to be discontinued at disease progression.

Renewal — (metastatic breast cancer) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology); and
- The cancer has not progressed at any time point during the previous 12 months whilst on lapatinib; and
- Lapatinib not to be given in combination with trastuzumab; and
- Lapatinib to be discontinued at disease progression.

NILOTINIB – Special Authority see [SA1489 on the next page](#) – Retail pharmacy

Wastage claimable			
Cap 150 mg	4,680.00	120	✓ Tasigna
Cap 200 mg	6,532.00	120	✓ Tasigna

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

►SA1489 Special Authority for Subsidy

Initial application only from a haematologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has a diagnosis of chronic myeloid leukaemia (CML) in blast crisis, accelerated phase, or in chronic phase; and
- 2 Either:
 - 2.1 Patient has documented CML treatment failure* with imatinib; or
 - 2.2 Patient has experienced treatment limiting toxicity with imatinib precluding further treatment with imatinib; and
- 3 Maximum nilotinib dose of 800 mg/day; and
- 4 Subsidised for use as monotherapy only.

Note: *treatment failure as defined by Leukaemia Net Guidelines.

Renewal only from a haematologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Lack of treatment failure while on nilotinib as defined by Leukaemia Net Guidelines; and
- 2 Nilotinib treatment remains appropriate and the patient is benefiting from treatment; and
- 3 Maximum nilotinib dose of 800 mg/day; and
- 4 Subsidised for use as monotherapy only.

PAZOPANIB – Special Authority see SA1190 below – Retail pharmacy

Tab 200 mg	1,334.70	30	✓ Votrient
Tab 400 mg	2,669.40	30	✓ Votrient

►SA1190 Special Authority for Subsidy

Initial application only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist.

Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 The patient has metastatic renal cell carcinoma; and
- 2 Any of the following:
 - 2.1 The patient is treatment naive; or
 - 2.2 The patient has only received prior cytokine treatment; or
 - 2.3 Both:
 - 2.3.1 The patient has discontinued sunitinib within 3 months of starting treatment due to intolerance; and
 - 2.3.2 The cancer did not progress whilst on sunitinib; and
- 3 The patient has good performance status (WHO/ECOG grade 0-2); and
- 4 The disease is of predominant clear cell histology; and
The patient has intermediate or poor prognosis defined as:
- 5 Any of the following:
 - 5.1 Lactate dehydrogenase level > 1.5 times upper limit of normal; or
 - 5.2 Haemoglobin level < lower limit of normal; or
 - 5.3 Corrected serum calcium level > 10 mg/dL (2.5 mmol/L); or
 - 5.4 Interval of < 1 year from original diagnosis to the start of systemic therapy; or
 - 5.5 Karnofsky performance score of less than or equal to 70; or
 - 5.6 2 or more sites of organ metastasis; and
- 6 Pazopanib to be used for a maximum of 3 months.

Renewal only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 3 months for applications meeting the following criteria:

Both:

- 1 No evidence of disease progression; and
- 2 The treatment remains appropriate and the patient is benefiting from treatment.

Notes: Pazopanib treatment should be stopped if disease progresses.

Poor prognosis patients are defined as having at least 3 of criteria 5.1-5.6. Intermediate prognosis patients are defined as having 1 or 2 of criteria 5.1-5.6.

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
RUXOLITINIB – Special Authority see SA1753 below – Retail pharmacy				
Wastage claimable				
Tab 5 mg	2,500.00	56	✓ Jakavi	
Tab 15 mg	5,000.00	56	✓ Jakavi	
Tab 20 mg	5,000.00	56	✓ Jakavi	

► [SA1753](#) Special Authority for Subsidy

Initial application only from a haematologist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient has primary myelofibrosis or post-polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis; and
- 2 A classification of risk of intermediate-2 or high-risk myelofibrosis according to either the International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or the Age-Adjusted DIPSS; and
- 3 A maximum dose of 20 mg twice daily is to be given.

Renewal only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 A maximum dose of 20 mg twice daily is to be given.

SUNITINIB – Special Authority see [SA1266 below](#) – Retail pharmacy

Cap 12.5 mg	2,315.38	28	✓ Sutent
Cap 25 mg	4,630.77	28	✓ Sutent
Cap 50 mg	9,261.54	28	✓ Sutent

► [SA1266](#) Special Authority for Subsidy

Initial application — (RCC) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 The patient has metastatic renal cell carcinoma; and
- 2 Any of the following:
 - 2.1 The patient is treatment naive; or
 - 2.2 The patient has only received prior cytokine treatment; or
 - 2.3 The patient has only received prior treatment with an investigational agent within the confines of a bona fide clinical trial which has Ethics Committee approval; or
 - 2.4 Both:
 - 2.4.1 The patient has discontinued pazopanib within 3 months of starting treatment due to intolerance; and
 - 2.4.2 The cancer did not progress whilst on pazopanib; and
- 3 The patient has good performance status (WHO/ECOG grade 0-2); and
- 4 The disease is of predominant clear cell histology; and
The patient has intermediate or poor prognosis defined as:
- 5 Any of the following:
 - 5.1 Lactate dehydrogenase level > 1.5 times upper limit of normal; or
 - 5.2 Haemoglobin level < lower limit of normal; or
 - 5.3 Corrected serum calcium level > 10 mg/dL (2.5 mmol/L); or
 - 5.4 Interval of < 1 year from original diagnosis to the start of systemic therapy; or
 - 5.5 Karnofsky performance score of less than or equal to 70; or
 - 5.6 2 or more sites of organ metastasis; and
- 6 Sunitinib to be used for a maximum of 2 cycles.

Initial application — (GIST) only from a relevant specialist or medical practitioner on the recommendation of a relevant

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

specialist. Approvals valid for 3 months for applications meeting the following criteria:

Both:

- 1 The patient has unresectable or metastatic malignant gastrointestinal stromal tumour (GIST); and
- 2 Either:
 - 2.1 The patient's disease has progressed following treatment with imatinib; or
 - 2.2 The patient has documented treatment-limiting intolerance, or toxicity to, imatinib.

Renewal — (RCC) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist.

Approvals valid for 3 months for applications meeting the following criteria:

Both:

- 1 No evidence of disease progression; and
- 2 The treatment remains appropriate and the patient is benefiting from treatment.

Notes: Sunitinib treatment should be stopped if disease progresses.

Poor prognosis patients are defined as having at least 3 of criteria 5.1-5.6. Intermediate prognosis patients are defined as having 1 or 2 of criteria 5.1-5.6

Renewal — (GIST) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist.

Approvals valid for 6 months for applications meeting the following criteria:

Both:

The patient has responded to treatment or has stable disease as determined by Choi's modified CT response evaluation criteria as follows:

- 1 Any of the following:
 - 1.1 The patient has had a complete response (disappearance of all lesions and no new lesions); or
 - 1.2 The patient has had a partial response (a decrease in size of 10% or more or decrease in tumour density in Hounsfield Units (HU) of 15% or more on CT and no new lesions and no obvious progression of non measurable disease); or
 - 1.3 The patient has stable disease (does not meet criteria the two above) and does not have progressive disease and no symptomatic deterioration attributed to tumour progression; and
- 2 The treatment remains appropriate and the patient is benefiting from treatment.

Note: It is recommended that response to treatment be assessed using Choi's modified CT response evaluation criteria (J Clin Oncol, 2007, 25:1753-1759). Progressive disease is defined as either: an increase in tumour size of 10% or more and not meeting criteria of partial response (PR) by tumour density (HU) on CT; or: new lesions, or new intratumoral nodules, or increase in the size of the existing intratumoral nodules.

Endocrine Therapy

For GnRH ANALOGUES – refer to HORMONE PREPARATIONS, Tropic Hormones, [page 84](#)

ABIRATERONE ACETATE – Retail pharmacy-Specialist – Special Authority see [SA1515 below](#)

Wastage claimable

Tab 250 mg	4,276.19	120	✓ Zytiga
------------------	----------	-----	----------

►SA1515 Special Authority for Subsidy

Initial application only from a medical oncologist, radiation oncologist, urologist or medical practitioner on the recommendation of a medical oncologist, radiation oncologist or urologist. Approvals valid for 5 months for applications meeting the following criteria:

All of the following:

- 1 Patient has prostate cancer; and
- 2 Patient has metastases; and
- 3 Patient's disease is castration resistant; and
- 4 Either:

continued...

ONCOLOGY AGENTS AND IMMUNOSUPPRESSANTS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

- 4.1 All of the following:
 - 4.1.1 Patient is symptomatic; and
 - 4.1.2 Patient has disease progression (rising serum PSA) after second line anti-androgen therapy; and
 - 4.1.3 Patient has ECOG performance score of 0-1; and
 - 4.1.4 Patient has not had prior treatment with taxane chemotherapy; or
- 4.2 All of the following:
 - 4.2.1 Patient's disease has progressed following prior chemotherapy containing a taxane; and
 - 4.2.2 Patient has ECOG performance score of 0-2; and
 - 4.2.3 Patient has not had prior treatment with abiraterone.

Renewal — (abiraterone acetate) only from a medical oncologist, radiation oncologist, urologist or medical practitioner on the recommendation of a medical oncologist, radiation oncologist or urologist. Approvals valid for 5 months for applications meeting the following criteria:

All of the following:

- 1 Significant decrease in serum PSA from baseline; and
- 2 No evidence of clinical disease progression; and
- 3 No initiation of taxane chemotherapy with abiraterone; and
- 4 The treatment remains appropriate and the patient is benefiting from treatment.

BICALUTAMIDE

Tab 50 mg	3.80	28	✓ Binarex
-----------------	------	----	------------------

FLUTAMIDE – Retail pharmacy-Specialist

Tab 250 mg	16.50	30	✓ Flutamide
	55.00	100	✓ Mylan ^{\$29}
			✓ Flutamin

MEGESTROL ACETATE – Retail pharmacy-Specialist

Tab 160 mg	63.53	30	✓ Apo-Megestrol
------------------	-------	----	------------------------

OCTREOTIDE

Inj 50 mcg per ml, 1 ml vial.....	30.64	5	✓ DBL Octreotide
Inj 100 mcg per ml, 1 ml vial.....	18.69	5	✓ DBL Octreotide
Inj 500 mcg per ml, 1 ml vial.....	72.50	5	✓ DBL Octreotide

OCTREOTIDE LAR (SOMATOSTATIN ANALOGUE) – Special Authority see [SA1016 below](#) – Retail pharmacy

Inj LAR 10 mg prefilled syringe.....	1,772.50	1	✓ Sandostatin LAR
Inj LAR 20 mg prefilled syringe.....	2,358.75	1	✓ Sandostatin LAR
Inj LAR 30 mg prefilled syringe.....	2,951.25	1	✓ Sandostatin LAR

► [SA1016](#) Special Authority for Subsidy

Initial application — (Malignant Bowel Obstruction) from any relevant practitioner. Approvals valid for 2 months for applications meeting the following criteria:

All of the following:

- 1 The patient has nausea* and vomiting* due to malignant bowel obstruction*; and
- 2 Treatment with antiemetics, rehydration, antimuscarinic agents, corticosteroids and analgesics for at least 48 hours has failed; and
- 3 Octreotide to be given at a maximum dose 1500 mcg daily for up to 4 weeks.

Note: Indications marked with * are unapproved indications.

Renewal — (Malignant Bowel Obstruction) from any relevant practitioner. Approvals valid for 3 months where the treatment remains appropriate and the patient is benefiting from treatment.

Initial application — (Acromegaly) only from a relevant specialist or medical practitioner on the recommendation of a relevant

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

specialist. Approvals valid for 3 months for applications meeting the following criteria:

Both:

- 1 The patient has acromegaly; and
- 2 Any of the following:
 - 2.1 Treatment with surgery, radiotherapy and a dopamine agonist has failed; or
 - 2.2 Treatment with octreotide is for an interim period while awaiting the effects of radiotherapy and a dopamine agonist has failed; or
 - 2.3 The patient is unwilling, or unable, to undergo surgery and/or radiotherapy.

Renewal — (Acromegaly) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist.

Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 IGF1 levels have decreased since starting octreotide; and
- 2 The treatment remains appropriate and the patient is benefiting from treatment.

Note: In patients with Acromegaly octreotide treatment should be discontinued if IGF1 levels have not decreased after 3 months treatment. In patients treated with radiotherapy octreotide treatment should be withdrawn every 2 years, for 1 month, for assessment of remission. Octreotide treatment should be stopped where there is biochemical evidence of remission (normal IGF1 levels) following octreotide treatment withdrawal for at least 4 weeks

Initial application — (Other Indications) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 2 years for applications meeting the following criteria:

Any of the following:

- 1 VIPomas and Glucagonomas - for patients who are seriously ill in order to improve their clinical state prior to definitive surgery; or
- 2 Both:
 - 2.1 Gastrinoma; and
 - 2.2 Either:
 - 2.2.1 Patient has failed surgery; or
 - 2.2.2 Patient in metastatic disease after H2 antagonists (or proton pump inhibitors) have failed; or
- 3 Both:
 - 3.1 Insulinomas; and
 - 3.2 Surgery is contraindicated or has failed; or
- 4 For pre-operative control of hypoglycaemia and for maintenance therapy; or
- 5 Both:
 - 5.1 Carcinoid syndrome (diagnosed by tissue pathology and/or urinary 5HIAA analysis); and
 - 5.2 Disabling symptoms not controlled by maximal medical therapy.

Note: The use of octreotide in patients with fistulae, oesophageal varices, miscellaneous diarrhoea and hypotension will not be funded as a Special Authority item

Renewal — (Other Indications) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 2 years where the treatment remains appropriate and the patient is benefiting from treatment.

TAMOXIFEN CITRATE

* Tab 10 mg	11.75	60	✓ Tamoxifen Sandoz
	19.50	100	✓ Genox
* Tab 20 mg	2.63	30	✓ Genox
	5.60	60	✓ Tamoxifen Sandoz
	12.50	100	✓ Genox

Aromatase Inhibitors

ANASTROZOLE

* Tab 1 mg	5.04	30	✓ Rolin
------------------	------	----	---------

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
EXEMESTANE				
* Tab 25 mg	14.50	30	✓	Pfizer Exemestane
LETROZOLE				
* Tab 2.5 mg	4.68	30	✓	Letrole
Letrole to be Sole Supply on 1 December 2018				

Immunosuppressants

Cytotoxic Immunosuppressants

AZATHIOPRINE – Retail pharmacy-Specialist

* Tab 25 mg	9.66	100	✓	Imuran
* Tab 50 mg	10.58	100	✓	Imuran
* Inj 50 mg vial	60.00	1	✓	Imuran

MYCOPHENOLATE MOFETIL

Tab 500 mg	25.00	50	✓	Cellcept
Cap 250 mg	25.00	100	✓	Cellcept
Powder for oral liq 1 g per 5 ml – Subsidy by endorsement	187.25	165 ml OP	✓	Cellcept

Mycophenolate powder for oral liquid is subsidised only for patients unable to swallow tablets and capsules, and when the prescription is endorsed accordingly.

Fusion Proteins

ETANERCEPT – Special Authority see [SA1620 below](#) – Retail pharmacy

Inj 25 mg	799.96	4	✓	Enbrel
Inj 50 mg autoinjector	1,599.96	4	✓	Enbrel
Inj 50 mg prefilled syringe	1,599.96	4	✓	Enbrel

► [SA1620](#) **Special Authority for Subsidy**

Initial application — (juvenile idiopathic arthritis) only from a named specialist or rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

- Either:
- 1 Both:
 - 1.1 The patient has had an initial Special Authority approval for adalimumab for juvenile idiopathic arthritis (JIA); and
 - 1.2 Either:
 - 1.2.1 The patient has experienced intolerable side effects from adalimumab; or
 - 1.2.2 The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for JIA; or
 - 2 All of the following:
 - 2.1 To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance; and
 - 2.2 Patient diagnosed with Juvenile Idiopathic Arthritis (JIA); and
 - 2.3 Patient has had severe active polyarticular course JIA for 6 months duration or longer; and
 - 2.4 Patient has tried and not responded to at least three months of oral or parenteral methotrexate (at a dose of 10-20 mg/m² weekly or at the maximum tolerated dose) in combination with either oral corticosteroids (prednisone 0.25 mg/kg or at the maximum tolerated dose) or a full trial of serial intra-articular corticosteroid injections; and
 - 2.5 Both:
 - 2.5.1 Either:
 - 2.5.1.1 Patient has persistent symptoms of poorly-controlled and active disease in at least 20 swollen, tender

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

joints; or

2.5.1.2 Patient has persistent symptoms of poorly-controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, shoulder, cervical spine, hip; and

2.5.2 Physician's global assessment indicating severe disease.

Initial application — (rheumatoid arthritis) only from a rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

Either:

1 Both:

1.1 The patient has had an initial Special Authority approval for adalimumab for rheumatoid arthritis; and

1.2 Either:

1.2.1 The patient has experienced intolerable side effects from adalimumab; or

1.2.2 The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for rheumatoid arthritis; or

2 All of the following:

2.1 Patient has had severe and active erosive rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic citrullinated peptide (CCP) antibody positive) for six months duration or longer; and

2.2 Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance; and

2.3 Patient has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a maximum tolerated dose; and

2.4 Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with sulfasalazine and hydroxychloroquine sulphate (at maximum tolerated doses); and

2.5 Any of the following:

2.5.1 Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with the maximum tolerated dose of ciclosporin; or

2.5.2 Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with intramuscular gold; or

2.5.3 Patient has tried and not responded to at least three months of therapy at the maximum tolerated dose of leflunomide alone or in combination with oral or parenteral methotrexate; and

2.6 Either:

2.6.1 Patient has persistent symptoms of poorly controlled and active disease in at least 20 swollen, tender joints; or

2.6.2 Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip; and

2.7 Either:

2.7.1 Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application; or

2.7.2 C-reactive protein levels not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months.

Initial application — (severe chronic plaque psoriasis) only from a dermatologist. Approvals valid for 4 months for applications meeting the following criteria:

Either:

1 Both:

1.1 The patient has had an initial Special Authority approval for adalimumab for severe chronic plaque psoriasis; and

1.2 Either:

1.2.1 The patient has experienced intolerable side effects from adalimumab; or

continued...

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
--	---	------------------------------	-------------------------------------

continued...

- 1.2.2 The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for severe chronic plaque psoriasis; or
- 2 All of the following:
 - 2.1 Either:
 - 2.1.1 Patient has "whole body" severe chronic plaque psoriasis with a Psoriasis Area and Severity Index (PASI) score of greater than 15, where lesions have been present for at least 6 months from the time of initial diagnosis; or
 - 2.1.2 Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis; and
 - 2.2 Patient has tried, but had an inadequate response (see Note) to, or has experienced intolerable side effects from, at least three of the following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, ciclosporin, or acitretin; and
 - 2.3 A PASI assessment has been completed for at least the most recent prior treatment course (but preferably all prior treatment courses), preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course; and
 - 2.4 The most recent PASI assessment is no more than 1 month old at the time of application.

Note: "Inadequate response" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 15, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the face, hand or foot, at least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very severe, and the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment.

Initial application — (ankylosing spondylitis) only from a rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

- Either:
- 1 Both:
 - 1.1 The patient has had an initial Special Authority approval for adalimumab for ankylosing spondylitis; and
 - 1.2 Either:
 - 1.2.1 The patient has experienced intolerable side effects from adalimumab; or
 - 1.2.2 The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for ankylosing spondylitis; or
 - 2 All of the following:
 - 2.1 Patient has a confirmed diagnosis of ankylosing spondylitis present for more than six months; and
 - 2.2 Patient has low back pain and stiffness that is relieved by exercise but not by rest; and
 - 2.3 Patient has bilateral sacroiliitis demonstrated by plain radiographs, CT or MRI scan; and
 - 2.4 Patient's ankylosing spondylitis has not responded adequately to treatment with two or more non-steroidal anti-inflammatory drugs (NSAIDs), in combination with anti-ulcer therapy if indicated, while patient was undergoing at least 3 months of a regular exercise regimen for ankylosing spondylitis; and
 - 2.5 Either:
 - 2.5.1 Patient has limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by the following Bath Ankylosing Spondylitis Metrology Index (BASMI) measures: a modified Schober's test of less than or equal to 4 cm and lumbar side flexion measurement of less than or equal to 10 cm (mean of left and right); or
 - 2.5.2 Patient has limitation of chest expansion by at least 2.5 cm below the average normal values corrected for age and gender (see Notes); and
 - 2.6 A Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) of at least 6 on a 0-10 scale.

Notes: The BASDAI must have been determined at the completion of the 3 month exercise trial, but prior to ceasing NSAID treatment. The BASDAI measure must be no more than 1 month old at the time of initial application.

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

Average normal chest expansion corrected for age and gender:

18-24 years - Male: 7.0 cm; Female: 5.5 cm

25-34 years - Male: 7.5 cm; Female: 5.5 cm

35-44 years - Male: 6.5 cm; Female: 4.5 cm

45-54 years - Male: 6.0 cm; Female: 5.0 cm

55-64 years - Male: 5.5 cm; Female: 4.0 cm

65-74 years - Male: 4.0 cm; Female: 4.0 cm

75+ years - Male: 3.0 cm; Female: 2.5 cm

Initial application — (psoriatic arthritis) only from a rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

Either:

1 Both:

1.1 The patient has had an initial Special Authority approval for adalimumab for psoriatic arthritis; and

1.2 Either:

1.2.1 The patient has experienced intolerable side effects from adalimumab; or

1.2.2 The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for psoriatic arthritis; or

2 All of the following:

2.1 Patient has had severe active psoriatic arthritis for six months duration or longer; and

2.2 Patient has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a maximum tolerated dose; and

2.3 Patient has tried and not responded to at least three months of sulfasalazine at a dose of at least 2 g per day or leflunomide at a dose of up to 20 mg daily (or maximum tolerated doses); and

2.4 Either:

2.4.1 Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen, tender joints; or

2.4.2 Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip; and

2.5 Any of the following:

2.5.1 Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application; or

2.5.2 Patient has an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour; or

2.5.3 ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months.

Initial application — (pyoderma gangrenosum) only from a dermatologist. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

1 Patient has pyoderma gangrenosum*; and

2 Patient has received three months of conventional therapy including a minimum of three pharmaceuticals (e.g. prednisone, ciclosporine, azathioprine, or methotrexate) and not received an adequate response; and

3 A maximum of 4 doses.

Note: Indications marked with * are unapproved indications.

Initial application — (adult-onset Still's disease) only from a rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

Either:

1 Both:

1.1 Either:

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

- 1.1.1 The patient has had an initial Special Authority approval for adalimumab for adult-onset Still's disease (AOSD); or
- 1.1.2 The patient has been started on tocilizumab for AOSD in a DHB hospital in accordance with the HML rules; and
- 1.2 Either:
 - 1.2.1 The patient has experienced intolerable side effects from adalimumab and/or tocilizumab; or
 - 1.2.2 The patient has received insufficient benefit from at least a three-month trial of adalimumab and/or tocilizumab such that they do not meet the renewal criteria for AOSD; or

2 All of the following:

- 2.1 Patient diagnosed with AOSD according to the Yamaguchi criteria (J Rheumatol 1992;19:424-430); and
- 2.2 Patient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, non-steroidal anti-inflammatory drugs (NSAIDs) and methotrexate; and
- 2.3 Patient has persistent symptoms of disabling poorly controlled and active disease.

Renewal — (juvenile idiopathic arthritis) only from a named specialist, rheumatologist or Practitioner on the recommendation of a named specialist or rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Either:
 - 1.1 Applicant is a named specialist or rheumatologist; or
 - 1.2 Applicant is a Practitioner and confirms that a named specialist or rheumatologist has provided a letter, email or fax recommending that the patient continues with etanercept treatment; and
- 2 Subsidised as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance; and
- 3 Either:
 - 3.1 Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baseline; or
 - 3.2 On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline.

Renewal — (rheumatoid arthritis) only from a rheumatologist or Practitioner on the recommendation of a rheumatologist.

Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Either:
 - 1.1 Applicant is a rheumatologist; or
 - 1.2 Applicant is a Practitioner and confirms that a rheumatologist has provided a letter, email or fax recommending that the patient continues with etanercept treatment; and
- 2 Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance; and
- 3 Either:
 - 3.1 Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician; or
 - 3.2 On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician; and
- 4 Etanercept to be administered at doses no greater than 50 mg every 7 days.

Renewal — (severe chronic plaque psoriasis) only from a dermatologist or Practitioner on the recommendation of a dermatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Either:
 - 1.1 Applicant is a dermatologist; or

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

- 1.2 Applicant is a Practitioner and confirms that a dermatologist has provided a letter, email or fax recommending that the patient continues with etanercept treatment; and
- 2 Either:
 - 2.1 Both:
 - 2.1.1 Patient had "whole body" severe chronic plaque psoriasis at the start of treatment; and
 - 2.1.2 Following each prior etanercept treatment course the patient has a PASI score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-treatment baseline value; or
 - 2.2 Both:
 - 2.2.1 Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment; and
 - 2.2.2 Either:
 - 2.2.2.1 Following each prior etanercept treatment course the patient has a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the treatment course baseline values; or
 - 2.2.2.2 Following each prior etanercept treatment course the patient has a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline value; and
- 3 Etanercept to be administered at doses no greater than 50 mg every 7 days.

Note: A treatment course is defined as a minimum of 12 weeks of etanercept treatment

Renewal — (ankylosing spondylitis) only from a rheumatologist or Practitioner on the recommendation of a rheumatologist.

Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Either:
 - 1.1 Applicant is a rheumatologist; or
 - 1.2 Applicant is a Practitioner and confirms that a rheumatologist has provided a letter, email or fax recommending that the patient continues with etanercept treatment; and
- 2 Following 12 weeks' initial treatment and for subsequent renewals, treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10 point scale, or an improvement in BASDAI of 50%, whichever is less; and
- 3 Physician considers that the patient has benefited from treatment and that continued treatment is appropriate; and
- 4 Etanercept to be administered at doses no greater than 50 mg every 7 days.

Renewal — (psoriatic arthritis) only from a rheumatologist or Practitioner on the recommendation of a rheumatologist.

Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Either:
 - 1.1 Applicant is a rheumatologist; or
 - 1.2 Applicant is a Practitioner and confirms that a rheumatologist has provided a letter, email or fax recommending that the patient continues with etanercept treatment; and
- 2 Either:
 - 2.1 Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician; or
 - 2.2 The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior etanercept treatment in the opinion of the treating physician; and
- 3 Etanercept to be administered at doses no greater than 50 mg every 7 days.

Renewal — (pyoderma gangrenosum) only from a dermatologist or Practitioner on the recommendation of a dermatologist.

Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Patient has shown clinical improvement; and

continued...

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

- 2 Patient continues to require treatment; and
- 3 A maximum of 4 doses.

Renewal — (adult-onset Still's disease) only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Either:
 - 1.1 Applicant is a rheumatologist; or
 - 1.2 Applicant is a Practitioner and confirms that a rheumatologist has provided a letter, email or fax recommending that the patient continues with etanercept treatment; and
- 2 The patient has a sustained improvement in inflammatory markers and functional status.

Immune Modulators

ANTITHYMOCYTE GLOBULIN (EQUINE) – PCT only – Specialist				
Inj 50 mg per ml, 5 ml	2,351.25	5	✓	ATGAM
BACILLUS CALMETTE-GUERIN (BCG) VACCINE – PCT only – Specialist				
Subsidised only for bladder cancer.				
Inj 2-8 x 100 million CFU	149.37	1	✓	OncoTICE

Monoclonal Antibodies

ADALIMUMAB – Special Authority see SA1742 below – Retail pharmacy				
Inj 20 mg per 0.4 ml prefilled syringe.....	1,599.96	2	✓	Humira
Inj 40 mg per 0.8 ml prefilled pen	1,599.96	2	✓	HumiraPen
Inj 40 mg per 0.8 ml prefilled syringe.....	1,599.96	2	✓	Humira

► [SA1742](#) Special Authority for Subsidy

Initial application — (rheumatoid arthritis) only from a rheumatologist. Approvals valid for 6 Months for applications meeting the following criteria:

Either:

- 1 Both:
 - 1.1 The patient has had an initial Special Authority approval for etanercept for rheumatoid arthritis; and
 - 1.2 Either:
 - 1.2.1 The patient has experienced intolerable side effects from etanercept; or
 - 1.2.2 The patient has received insufficient benefit from etanercept to meet the renewal criteria for etanercept for rheumatoid arthritis; or
- 2 All of the following:
 - 2.1 Patient has had severe and active erosive rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic citrullinated peptide (CCP) antibody positive) for six months duration or longer; and
 - 2.2 Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance; and
 - 2.3 Patient has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a maximum tolerated dose; and
 - 2.4 Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with sulfasalazine and hydroxychloroquine sulphate (at maximum tolerated doses); and
 - 2.5 Any of the following:
 - 2.5.1 Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with the maximum tolerated dose of ciclosporin; or

continued...

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
---	-----	--------------------------	-------------------------------------

continued...

- 2.5.2 Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with intramuscular gold; or
- 2.5.3 Patient has tried and not responded to at least three months of therapy at the maximum tolerated dose of leflunomide alone or in combination with oral or parenteral methotrexate; and
- 2.6 Either:
 - 2.6.1 Patient has persistent symptoms of poorly controlled and active disease in at least 20 swollen, tender joints; or
 - 2.6.2 Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip; and
- 2.7 Either:
 - 2.7.1 Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application; or
 - 2.7.2 C-reactive protein levels not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months.

Initial application — (Crohn's disease - adults) only from a gastroenterologist. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 Patient has severe active Crohn's disease; and
- 2 Any of the following:
 - 2.1 Patient has a Crohn's Disease Activity Index (CDAI) score of greater than or equal to 300; or
 - 2.2 Patient has extensive small intestine disease affecting more than 50 cm of the small intestine; or
 - 2.3 Patient has evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel resection; or
 - 2.4 Patient has an ileostomy or colostomy, and has intestinal inflammation; and
- 3 Patient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior systemic therapy with immunomodulators at maximum tolerated doses (unless contraindicated) and corticosteroids; and
- 4 Surgery (or further surgery) is considered to be clinically inappropriate.

Initial application — (Crohn's disease - children) only from a gastroenterologist. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 Paediatric patient has severe active Crohn's disease; and
- 2 Either:
 - 2.1 Patient has a Paediatric Crohn's Disease Activity Index (PCDAI) score of greater than or equal to 30; or
 - 2.2 Patient has extensive small intestine disease; and
- 3 Patient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior systemic therapy with immunomodulators at maximum tolerated doses (unless contraindicated) and corticosteroids; and
- 4 Surgery (or further surgery) is considered to be clinically inappropriate.

Initial application — (severe chronic plaque psoriasis) only from a dermatologist. Approvals valid for 4 months for applications meeting the following criteria:

Either:

- 1 Both:
 - 1.1 The patient has had an initial Special Authority approval for etanercept for severe chronic plaque psoriasis; and
 - 1.2 Either:
 - 1.2.1 The patient has experienced intolerable side effects from etanercept; or
 - 1.2.2 The patient has received insufficient benefit from etanercept to meet the renewal criteria for etanercept for severe chronic plaque psoriasis; or
- 2 All of the following:

continued...

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

2.1 Either:

2.1.1 Patient has "whole body" severe chronic plaque psoriasis with a Psoriasis Area and Severity Index (PASI) score of greater than 15, where lesions have been present for at least 6 months from the time of initial diagnosis; or

2.1.2 Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis; and

2.2 Patient has tried, but had an inadequate response (see Note) to, or has experienced intolerable side effects from, at least three of the following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, cyclosporin, or acitretin; and

2.3 A PASI assessment has been completed for at least the most recent prior treatment course (but preferably all prior treatment courses), preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course; and

2.4 The most recent PASI assessment is no more than 1 month old at the time of application.

Note: "Inadequate response" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 15, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the face, hand or foot, at least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very severe, and the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment.

Initial application — (ankylosing spondylitis) only from a rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

Either:

1 Both:

1.1 The patient has had an initial Special Authority approval for etanercept for ankylosing spondylitis; and

1.2 Either:

1.2.1 The patient has experienced intolerable side effects from etanercept; or

1.2.2 The patient has received insufficient benefit from etanercept to meet the renewal criteria for etanercept for ankylosing spondylitis; or

2 All of the following:

2.1 Patient has a confirmed diagnosis of ankylosing spondylitis for more than six months; and

2.2 Patient has low back pain and stiffness that is relieved by exercise but not by rest; and

2.3 Patient has bilateral sacroiliitis demonstrated by plain radiographs, CT or MRI scan; and

2.4 Patient's ankylosing spondylitis has not responded adequately to treatment with two or more non-steroidal anti-inflammatory drugs (NSAIDs), in combination with anti-ulcer therapy if indicated, while patient was undergoing at least 3 months of a regular exercise regimen for ankylosing spondylitis; and

2.5 Either:

2.5.1 Patient has limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by the following Bath Ankylosing Spondylitis Metrology Index (BASMI) measures: a modified Schober's test of less than or equal to 4 cm and lumbar side flexion measurement of less than or equal to 10 cm (mean of left and right); or

2.5.2 Patient has limitation of chest expansion by at least 2.5 cm below the following average normal values corrected for age and gender (see Notes); and

2.6 A Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) of at least 6 on a 0-10 scale.

Notes: The BASDAI must have been determined at the completion of the 3 month exercise trial, but prior to ceasing NSAID treatment. The BASDAI measure must be no more than 1 month old at the time of initial application.

Average normal chest expansion corrected for age and gender:

18-24 years - Male: 7.0 cm; Female: 5.5 cm

25-34 years - Male: 7.5 cm; Female: 5.5 cm

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

35-44 years - Male: 6.5 cm; Female: 4.5 cm

45-54 years - Male: 6.0 cm; Female: 5.0 cm

55-64 years - Male: 5.5 cm; Female: 4.0 cm

65-74 years - Male: 4.0 cm; Female: 4.0 cm

75+ years - Male: 3.0 cm; Female: 2.5 cm

Initial application — (psoriatic arthritis) only from a rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

Either:

1 Both:

1.1 The patient has had an initial Special Authority approval for etanercept for psoriatic arthritis; and

1.2 Either:

1.2.1 The patient has experienced intolerable side effects from etanercept; or

1.2.2 The patient has received insufficient benefit from etanercept to meet the renewal criteria for etanercept for psoriatic arthritis; or

2 All of the following:

2.1 Patient has had severe active psoriatic arthritis for six months duration or longer; and

2.2 Patient has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a maximum tolerated dose; and

2.3 Patient has tried and not responded to at least three months of sulfasalazine at a dose of at least 2 g per day or leflunomide at a dose of up to 20 mg daily (or maximum tolerated doses); and

2.4 Either:

2.4.1 Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen, tender joints; or

2.4.2 Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip; and

2.5 Any of the following:

2.5.1 Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application; or

2.5.2 Patient has an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour; or

2.5.3 ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months.

Initial application — (juvenile idiopathic arthritis) only from a named specialist or rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

Either:

1 Both:

1.1 The patient has had an initial Special Authority approval for etanercept for juvenile idiopathic arthritis (JIA); and

1.2 Either:

1.2.1 The patient has experienced intolerable side effects from etanercept; or

1.2.2 The patient has received insufficient benefit from etanercept to meet the renewal criteria for etanercept for juvenile idiopathic arthritis; or

2 All of the following:

2.1 To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance; and

2.2 Patient diagnosed with JIA; and

2.3 Patient has had severe active polyarticular course JIA for 6 months duration or longer; and

2.4 Patient has tried and not responded to at least three months of oral or parenteral methotrexate (at a dose of 10-20 mg/m² weekly or at the maximum tolerated dose) in combination with either oral corticosteroids (prednisone

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

- 0.25 mg/kg or at the maximum tolerated dose) or a full trial of serial intra-articular corticosteroid injections; and
- 2.5 Both:
- 2.5.1 Either:
- 2.5.1.1 Patient has persistent symptoms of poorly-controlled and active disease in at least 20 swollen, tender joints; or
- 2.5.1.2 Patient has persistent symptoms of poorly-controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, shoulder, cervical spine, hip; and
- 2.5.2 Physician's global assessment indicating severe disease.

Initial application — (fistulising Crohn's disease) only from a gastroenterologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has confirmed Crohn's disease; and
- 2 Either:
 - 2.1 Patient has one or more complex externally draining enterocutaneous fistula(e); or
 - 2.2 Patient has one or more rectovaginal fistula(e); and
- 3 A Baseline Fistula Assessment has been completed and is no more than 1 month old at the time of application; and
- 4 The patient will be assessed for response to treatment after 4 months' adalimumab treatment (see Note).

Note: A maximum of 4 months' adalimumab will be subsidised on an initial Special Authority approval for fistulising Crohn's disease.

Initial application — (pyoderma gangrenosum) only from a dermatologist. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Patient has pyoderma gangrenosum*; and
- 2 Patient has received three months of conventional therapy including a minimum of three pharmaceuticals (e.g. prednisone, ciclosporin, azathioprine, or methotrexate) and not received an adequate response; and
- 3 A maximum of 4 doses.

Note: Note: Indications marked with * are unapproved indications.

Initial application — (adult-onset Still's disease) only from a rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Both:
 - 1.1 Either:
 - 1.1.1 The patient has had an initial Special Authority approval for etanercept for adult-onset Still's disease (AOSD); or
 - 1.1.2 The patient has been started on tocilizumab for AOSD in a DHB hospital in accordance with the HML rules; and
 - 1.2 Either:
 - 1.2.1 The patient has experienced intolerable side effects from etanercept and/or tocilizumab; or
 - 1.2.2 The patient has received insufficient benefit from at least a three-month trial of etanercept and/or tocilizumab such that they do not meet the renewal criteria for AOSD; or
- 2 All of the following:
 - 2.1 Patient diagnosed with AOSD according to the Yamaguchi criteria (J Rheumatol 1992;19:424-430); and
 - 2.2 Patient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, non-steroidal anti-inflammatory drugs (NSAIDs) and methotrexate; and
 - 2.3 Patient has persistent symptoms of disabling poorly controlled and active disease.

Renewal — (rheumatoid arthritis) only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

All of the following:

- 1 Either:
 - 1.1 Applicant is a rheumatologist; or
 - 1.2 Applicant is a Practitioner and confirms that a rheumatologist has provided a letter, email or fax recommending that the patient continues with adalimumab treatment; and
- 2 Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance; and
- 3 Either:
 - 3.1 Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician; or
 - 3.2 On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician; and
- 4 Either:
 - 4.1 Adalimumab to be administered at doses no greater than 40 mg every 14 days; or
 - 4.2 Patient cannot take concomitant methotrexate and requires doses of adalimumab higher than 40 mg every 14 days to maintain an adequate response.

Renewal — (Crohn's disease - adults) only from a gastroenterologist or Practitioner on the recommendation of a gastroenterologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Either:
 - 1.1 Applicant is a gastroenterologist; or
 - 1.2 Applicant is a Practitioner and confirms that a gastroenterologist has provided a letter, email or fax recommending that the patient continues with adalimumab treatment; and
- 2 Either:
 - 2.1 Either:
 - 2.1.1 CDAI score has reduced by 100 points from the CDAI score when the patient was initiated on adalimumab; or
 - 2.1.2 CDAI score is 150 or less; or
 - 2.2 Both:
 - 2.2.1 The patient has demonstrated an adequate response to treatment but CDAI score cannot be assessed; and
 - 2.2.2 Applicant to indicate the reason that CDAI score cannot be assessed; and
- 3 Adalimumab to be administered at doses no greater than 40 mg every 14 days.

Renewal — (Crohn's disease - children) only from a gastroenterologist or Practitioner on the recommendation of a gastroenterologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Either:
 - 1.1 Applicant is a gastroenterologist; or
 - 1.2 Applicant is a Practitioner and confirms that a gastroenterologist has provided a letter, email or fax recommending that the patient continues with adalimumab treatment; and
- 2 Either:
 - 2.1 Either:
 - 2.1.1 PCDAI score has reduced by 10 points from the PCDAI score when the patient was initiated on adalimumab; or
 - 2.1.2 PCDAI score is 15 or less; or
 - 2.2 Both:
 - 2.2.1 The patient has demonstrated an adequate response to treatment but PCDAI score cannot be assessed; and

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

2.2.2 Applicant to indicate the reason that PCDAI score cannot be assessed; and

3 Adalimumab to be administered at doses no greater than 40 mg every 14 days.

Renewal — (severe chronic plaque psoriasis) only from a dermatologist or Practitioner on the recommendation of a dermatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

1 Either:

1.1 Applicant is a dermatologist; or

1.2 Applicant is a Practitioner and confirms that a dermatologist has provided a letter, email or fax recommending that the patient continues with adalimumab treatment; and

2 Either:

2.1 Both:

2.1.1 Patient had "whole body" severe chronic plaque psoriasis at the start of treatment; and

2.1.2 Following each prior adalimumab treatment course the patient has a PASI score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-adalimumab treatment baseline value; or

2.2 Both:

2.2.1 Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment; and

2.2.2 Either:

2.2.2.1 Following each prior adalimumab treatment course the patient has a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the treatment course baseline values; or

2.2.2.2 Following each prior adalimumab treatment course the patient has a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-adalimumab treatment baseline value; and

3 Adalimumab to be administered at doses no greater than 40 mg every 14 days.

Note: A treatment course is defined as a minimum of 12 weeks adalimumab treatment

Renewal — (ankylosing spondylitis) only from a rheumatologist or Practitioner on the recommendation of a rheumatologist.

Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

1 Either:

1.1 Applicant is a rheumatologist; or

1.2 Applicant is a Practitioner and confirms that a rheumatologist has provided a letter, email or fax recommending that the patient continues with adalimumab treatment; and

2 Following 12 weeks' initial treatment and for subsequent renewals, treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10 point scale, or an improvement in BASDAI of 50%, whichever is less; and

3 Physician considers that the patient has benefited from treatment and that continued treatment is appropriate; and

4 Adalimumab to be administered at doses no greater than 40 mg every 14 days.

Renewal — (psoriatic arthritis) only from a rheumatologist or Practitioner on the recommendation of a rheumatologist.

Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

1 Either:

1.1 Applicant is a rheumatologist; or

1.2 Applicant is a Practitioner and confirms that a rheumatologist has provided a letter, email or fax recommending that the patient continues with adalimumab treatment; and

2 Either:

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

- 2.1 Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician; or
- 2.2 The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior adalimumab treatment in the opinion of the treating physician; and
- 3 Adalimumab to be administered at doses no greater than 40 mg every 14 days.

Renewal — (juvenile idiopathic arthritis) only from a named specialist, rheumatologist or Practitioner on the recommendation of a named specialist or rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Either:
 - 1.1 Applicant is a named specialist or rheumatologist; or
 - 1.2 Applicant is a Practitioner and confirms that a named specialist or rheumatologist has provided a letter, email or fax recommending that the patient continues with adalimumab treatment; and
- 2 Subsidised as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance; and
- 3 Either:
 - 3.1 Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baseline; or
 - 3.2 On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline.

Renewal — (fistulising Crohn's disease) only from a gastroenterologist or Practitioner on the recommendation of a gastroenterologist. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Either:
 - 1.1 Applicant is a gastroenterologist; or
 - 1.2 Applicant is a Practitioner and confirms that a gastroenterologist has provided a letter, email or fax recommending that the patient continues with adalimumab treatment; and
- 2 Either:
 - 2.1 The number of open draining fistulae have decreased from baseline by at least 50%; or
 - 2.2 There has been a marked reduction in drainage of all fistula(e) from baseline as demonstrated by a reduction in the Fistula Assessment score, together with less induration and patient-reported pain.

Renewal — (pyoderma gangrenosum) only from a dermatologist or Practitioner on the recommendation of a dermatologist.

Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Patient has shown clinical improvement; and
- 2 Patient continues to require treatment; and
- 3 A maximum of 4 doses.

Renewal — (adult-onset Still's disease) only from a rheumatologist or Practitioner on the recommendation of a rheumatologist.

Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Either:
 - 1.1 Applicant is a rheumatologist; or
 - 1.2 Applicant is a Practitioner and confirms that a rheumatologist has provided a letter, email or fax recommending that the patient continues with adalimumab treatment; and
- 2 The patient has a sustained improvement in inflammatory markers and functional status.

AFLIBERCEPT – Special Authority see [SA1726 on the next page](#) – Retail pharmacy

Inj 40 mg per ml, 0.1 ml vial..... 1,250.00 1 ✓ Eylea

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

►SA1726 Special Authority for Subsidy

Initial application — (wet age related macular degeneration) only from an ophthalmologist. Approvals valid for 3 months for applications meeting the following criteria:

- Either:
- All of the following:
 - Any of the following:
 - Wet age-related macular degeneration (wet AMD); or
 - Polypoidal choroidal vasculopathy; or
 - Choroidal neovascular membrane from causes other than wet AMD; and
 - Either:
 - The patient has developed severe endophthalmitis or severe posterior uveitis following treatment with bevacizumab; or
 - There is worsening of vision or failure of retina to dry despite three intraocular injections of bevacizumab four weeks apart; and
 - There is no structural damage to the central fovea of the treated eye; and
 - Patient has not previously been treated with ranibizumab for longer than 3 months; or
 - Any of the following:
 - Patient has current approval to use ranibizumab for treatment of wAMD and was found to be intolerant to ranibizumab within 3 months; or
 - Patient has previously* (*before June 2018) received treatment with ranibizumab for wAMD and disease was stable while on treatment; or
 - Patient has current approval to use ranibizumab for treatment of wAMD; or
 - Patient is currently receiving treatment with aflibercept and has documented previous poor response to bevacizumab.

Note: Criteria 2.3 and 2.4 will be removed from 1 January 2019.

Initial application — (diabetic macular oedema) only from an ophthalmologist. Approvals valid for 4 months for applications meeting the following criteria:

- Either:
- All of the following:
 - Patient has centre involving diabetic macular oedema (DMO); and
 - Patient's disease is non responsive to 4 doses of intravitreal bevacizumab when administered 4-6 weekly; and
 - Patient has reduced visual acuity between 6/9 – 6/36 with functional awareness of reduction in vision; and
 - Patient has DMO within central OCT (ocular coherence tomography) subfield > 350 micrometers; and
 - There is no centre-involving sub-retinal fibrosis or foveal atrophy; or
 - Patient is currently receiving treatment with aflibercept and has documented previous poor response to bevacizumab.

Note: Criterion 2 will be removed from 1 January 2019.

Renewal — (wet age related macular degeneration) only from an ophthalmologist. Approvals valid for 12 months for applications meeting the following criteria:

- All of the following:
- Documented benefit must be demonstrated to continue; and
 - Patient's vision is 6/36 or better on the Snellen visual acuity score; and
 - There is no structural damage to the central fovea of the treated eye.

Renewal — (diabetic macular oedema) only from an ophthalmologist. Approvals valid for 12 months for applications meeting the following criteria:

- All of the following:
- There is stability or two lines of Snellen visual acuity gain; and

continued...

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
--	---	------------------------------	-------------------------------------

continued...

- 2 There is structural improvement on OCT scan (with reduction in intra-retinal cysts, central retinal thickness, and sub-retinal fluid); and
- 3 Patient's vision is 6/36 or better on the Snellen visual acuity score; and
- 4 There is no centre-involving sub-retinal fibrosis or foveal atrophy; and
- 5 After each consecutive 12 months treatment with (2nd line anti-VEGF agent), patient has retrialled with at least one injection of bevacizumab and had no response.

CETUXIMAB – PCT only – Specialist – Special Authority see [SA1697 below](#)

Inj 5 mg per ml, 20 ml vial.....	364.00	1	✓ Erbitux
Inj 5 mg per ml, 100 ml vial.....	1,820.00	1	✓ Erbitux
Inj 1 mg for ECP	3.82	1 mg	✓ Baxter

► **SA1697 Special Authority for Subsidy**

Initial application only from a medical oncologist or medical practitioner on the recommendation of a medical oncologist.

Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has locally advanced, non-metastatic, squamous cell cancer of the head and neck; and
- 2 Patient is contraindicated to, or is intolerant of, cisplatin; and
- 3 Patient has good performance status; and
- 4 To be administered in combination with radiation therapy.

OBINUTUZUMAB – PCT only – Specialist – Special Authority see [SA1627 below](#)

Inj 25 mg per ml, 40 ml vial.....	5,910.00	1	✓ Gazyva
Inj 1 mg for ECP	6.21	1 mg	✓ Baxter

► **SA1627 Special Authority for Subsidy**

Initial application — (chronic lymphocytic leukaemia) only from a haematologist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient has progressive Binet stage A, B or C CD20+ chronic lymphocytic leukaemia requiring treatment; and
- 2 The patient is obinutuzumab treatment naive; and
- 3 The patient is not eligible for full dose FCR due to comorbidities with a score > 6 on the Cumulative Illness Rating Scale (CIRS) or reduced renal function (creatinine clearance < 70mL/min); and
- 4 Patient has adequate neutrophil and platelet counts* unless the cytopenias are a consequence of marrow infiltration by CLL; and
- 5 Patient has good performance status; and
- 6 Obinutuzumab to be administered at a maximum cumulative dose of 8,000 mg and in combination with chlorambucil for a maximum of 6 cycles.

Notes: Chronic lymphocytic leukaemia includes small lymphocytic lymphoma. Comorbidity refers only to illness/impairment other than CLL induced illness/impairment in the patient. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL disease symptoms a higher ECOG (2 or 3) is acceptable where treatment with obinutuzumab is expected to improve symptoms and improve ECOG score to < 2.

* Neutrophil greater than or equal to $1.5 \times 10^9/L$ and platelets greater than or equal to $75 \times 10^9/L$.

OMALIZUMAB – Special Authority see [SA1744 below](#) – Retail pharmacy

Inj 150 mg prefilled syringe.....	450.00	1	✓ Xolair
Inj 150 mg vial	450.00	1	✓ Xolair

► **SA1744 Special Authority for Subsidy**

Initial application — (severe asthma) only from a respiratory specialist or clinical immunologist. Approvals valid for 6 months for applications meeting the following criteria:

continued...

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

* Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
--	---	------------------------------	-------------------------------------

continued...

All of the following:

- 1 Patient must be aged 6 years or older; and
- 2 Patient has a diagnosis of severe asthma; and
- 3 Past or current evidence of atopy, documented by skin prick testing or RAST; and
- 4 Total serum human immunoglobulin E (IgE) between 76 IU/mL and 1300 IU/ml at baseline; and
- 5 Proven adherence with optimal inhaled therapy including high dose inhaled corticosteroid (budesonide 1,600 mcg per day or fluticasone propionate 1,000 mcg per day or equivalent), plus long-acting beta-2 agonist therapy (at least salmeterol 50 mcg bd or formoterol 12 mcg bd) for at least 12 months, unless contraindicated or not tolerated; and
- 6 Either:
 - 6.1 Patient has received courses of systemic corticosteroids equivalent to at least 28 days treatment in the past 12 months, unless contraindicated or not tolerated; or
 - 6.2 Patient has had at least 4 exacerbations needing systemic corticosteroids in the previous 12 months, where an exacerbation is defined as either documented use of oral corticosteroids for at least 3 days or parenteral steroids; and
- 7 Patient has an Asthma Control Test (ACT) score of 10 or less; and
- 8 Baseline measurements of the patient's asthma control using the ACT and oral corticosteroid dose must be made at the time of application, and again at around 26 weeks after the first dose to assess response to treatment.

Initial application — (severe chronic spontaneous urticaria) only from a clinical immunologist or dermatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient must be aged 12 years or older; and
- 2 Either:
 - 2.1 Both:
 - 2.1.1 Patient is symptomatic with Urticaria Activity Score 7 (UAS7) of 20 or above; and
 - 2.1.2 Patient has a Dermatology life quality index (DLQI) of 10 or greater; or
 - 2.2 Patient has a Urticaria Control Test (UCT) of 8 or less; and
- 3 Any of the following:
 - 3.1 Patient has been taking high dose antihistamines (e.g. 4 times standard dose) and ciclosporin (> 3 mg/kg day) for at least 6 weeks; or
 - 3.2 Patient has been taking high dose antihistamines (e.g. 4 times standard dose) and at least 3 courses of systemic corticosteroids (> 20 mg prednisone per day for at least 5 days) in the previous 6 months; or
 - 3.3 Patient has developed significant adverse effects whilst on corticosteroids or ciclosporin; and
- 4 Either:
 - 4.1 Treatment to be stopped if inadequate response* following 4 doses; or
 - 4.2 Complete response* to 6 doses of omalizumab.

Renewal — (severe asthma) only from a clinical immunologist or respiratory specialist. Approvals valid for 2 years for applications meeting the following criteria:

- Both:
- 1 An increase in the Asthma Control Test (ACT) score of at least 5 from baseline; and
 - 2 A reduction in the maintenance oral corticosteroid dose or number of exacerbations of at least 50% from baseline.

Renewal — (severe chronic spontaneous urticaria) only from a clinical immunologist or dermatologist. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Patient has previously adequately responded* to 6 doses of omalizumab; or
- 2 Both:
 - 2.1 Patient has previously had a complete response* to 6 doses of omalizumab; and
 - 2.2 Patient has relapsed after cessation of omalizumab therapy.

continued...

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
--	---	----------------------------	-------------------------------------

continued...

Note: *Inadequate response defined as less than 50% reduction in baseline UAS7 and DLQI score, or an increase in Urticaria Control Test (UCT) score of less than 4 from baseline. Patient is to be reassessed for response after 4 doses of omalizumab. Complete response is defined as UAS7 less than or equal to 6 and DLQI less than or equal to 5; or UCT of 16. Relapse of chronic urticaria on stopping prednisone/ciclosporin does not justify the funding of omalizumab.

PERTUZUMAB – PCT only – Specialist – Special Authority see [SA1606 below](#)

Inj 30 mg per ml, 14 ml vial.....	3,927.00	1	✓ Perjeta
Inj 420 mg for ECP	3,927.00	420 mg OP	✓ Baxter

➔**SA1606** **Special Authority for Subsidy**

Initial application — (metastatic breast cancer) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology); and
- 2 Either:
 - 2.1 Patient is chemotherapy treatment naïve; or
 - 2.2 Patient has not received prior treatment for their metastatic disease and has had a treatment free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer; and
- 3 The patient has good performance status (ECOG grade 0-1); and
- 4 Pertuzumab to be administered in combination with trastuzumab; and
- 5 Pertuzumab maximum first dose of 840 mg, followed by maximum of 420 mg every 3 weeks; and
- 6 Pertuzumab to be discontinued at disease progression.

Renewal — (metastatic breast cancer) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology); and
- 2 The cancer has not progressed at any time point during the previous 12 months whilst on pertuzumab and trastuzumab.

RITUXIMAB – PCT only – Specialist – Special Authority see [SA1686 below](#)

Inj 100 mg per 10 ml vial	1,075.50	2	✓ Mabthera
Inj 500 mg per 50 ml vial	2,688.30	1	✓ Mabthera
Inj 1 mg for ECP	5.64	1 mg	✓ Baxter

➔**SA1686** **Special Authority for Subsidy**

Initial application — (Post-transplant) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 The patient has B-cell post-transplant lymphoproliferative disorder*; and
- 2 To be used for a maximum of 8 treatment cycles.

Note: Indications marked with * are unapproved indications.

Initial application — (Indolent, Low-grade lymphomas or hairy cell leukaemia*) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 9 months for applications meeting the following criteria:

Either:

- 1 Both:
 - 1.1 The patient has indolent low grade NHL or hairy cell leukaemia* with relapsed disease following prior chemotherapy; and
 - 1.2 To be used for a maximum of 6 treatment cycles; or

continued...

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
--	---	------------------------------	-------------------------------------

continued...

2 Both:

- 2.1 The patient has indolent, low grade lymphoma or hairy cell leukaemia* requiring first-line systemic chemotherapy; and
- 2.2 To be used for a maximum of 6 treatment cycles.

Note: 'Indolent, low-grade lymphomas' includes follicular, mantle, marginal zone and lymphoplasmacytic/Waldenstrom macroglobulinaemia. *Hairy cell leukaemia includes hairy cell leukaemia variant *Unapproved indication.

Initial application — (Aggressive CD20 positive NHL) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

Either:

1 All of the following:

- 1.1 The patient has treatment naive aggressive CD20 positive NHL; and
- 1.2 To be used with a multi-agent chemotherapy regimen given with curative intent; and
- 1.3 To be used for a maximum of 8 treatment cycles; or

2 Both:

- 2.1 The patient has aggressive CD20 positive NHL with relapsed disease following prior chemotherapy; and
- 2.2 To be used for a maximum of 6 treatment cycles.

Note: 'Aggressive CD20 positive NHL' includes large B-cell lymphoma and Burkitt's lymphoma/leukaemia

Initial application — (Chronic Lymphocytic Leukaemia) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient has progressive Binet stage A, B or C chronic lymphocytic leukaemia (CLL) requiring treatment; and
- 2 The patient is rituximab treatment naive; and
- 3 Either:
 - 3.1 The patient is chemotherapy treatment naive; or
 - 3.2 Both:
 - 3.2.1 The patient's disease has relapsed following no more than three prior lines of chemotherapy treatment; and
 - 3.2.2 The patient has had a treatment-free interval of 12 months or more if previously treated with fludarabine and cyclophosphamide chemotherapy; and
- 4 The patient has good performance status; and
- 5 The patient does not have chromosome 17p deletion CLL; and
- 6 Rituximab to be administered in combination with fludarabine and cyclophosphamide or bendamustine for a maximum of 6 treatment cycles; and
- 7 It is planned that the patient receives full dose fludarabine and cyclophosphamide (orally or dose equivalent intravenous administration) or bendamustine.

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma. A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL disease symptoms a higher ECOG (2 or 3) is acceptable where treatment with rituximab is expected to improve symptoms and improve ECOG score to < 2.

Renewal — (Post-transplant) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 9 months for applications meeting the following criteria:

All of the following:

- 1 The patient has had a rituximab treatment-free interval of 12 months or more; and
- 2 The patient has B-cell post-transplant lymphoproliferative disorder; and
- 3 To be used for no more than 6 treatment cycles.

Note: Indications marked with * are unapproved indications.

Renewal — (Indolent, Low-grade lymphomas or hairy cell leukaemia*) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 9 months for applications meeting the following criteria:

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

All of the following:

- 1 The patient has had a rituximab treatment-free interval of 12 months or more; and
- 2 The patient has indolent, low-grade NHL or hairy cell leukaemia* with relapsed disease following prior chemotherapy; and
- 3 To be used for no more than 6 treatment cycles.

Note: 'Indolent, low-grade lymphomas' includes follicular, mantle, marginal zone and lymphoplasmacytic/Waldenstrom macroglobulinaemia. *Hairy cell leukaemia includes hairy cell leukaemia variant *Unapproved indication.

Renewal — (Aggressive CD20 positive NHL) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient has had a rituximab treatment-free interval of 12 months or more; and
- 2 The patient has relapsed refractory/aggressive CD20 positive NHL; and
- 3 To be used with a multi-agent chemotherapy regimen given with curative intent; and
- 4 To be used for a maximum of 4 treatment cycles.

Note: 'Aggressive CD20 positive NHL' includes large B-cell lymphoma and Burkitt's lymphoma/leukaemia

Renewal — (Chronic Lymphocytic Leukaemia) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient's disease has relapsed following no more than one prior line of treatment with rituximab for CLL; and
- 2 The patient has had an interval of 36 months or more since commencement of initial rituximab treatment; and
- 3 The patient does not have chromosome 17p deletion CLL; and
- 4 It is planned that the patient receives full dose fludarabine and cyclophosphamide (orally or dose equivalent intravenous administration) or bendamustine; and
- 5 Rituximab to be administered in combination with fludarabine and cyclophosphamide or bendamustine for a maximum of 6 treatment cycles.

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma. A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments.

SECUKINUMAB – Special Authority see [SA1754 below](#) – Retail pharmacy

Inj 150 mg per ml, 1 ml prefilled syringe..... 1,599.00 2 ✓ Cosentyx

► **SA1754 Special Authority for Subsidy**

Initial application — (severe chronic plaque psoriasis – second-line biologic) only from a dermatologist. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 The patient has had an initial Special Authority approval for adalimumab or etanercept, or has trialled infliximab in a DHB hospital in accordance with the General Rules of the Pharmaceutical Schedule, for severe chronic plaque psoriasis; and
- 2 Either:
 - 2.1 The patient has experienced intolerable side effects from adalimumab, etanercept or infliximab; or
 - 2.2 The patient has received insufficient benefit from adalimumab, etanercept or infliximab; and
- 3 A Psoriasis Area and Severity Index (PASI) assessment or Dermatology Quality of Life Index (DLQI) assessment has been completed for at least the most recent prior treatment course, preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course; and
- 4 The most recent PASI or DQI assessment is no more than 1 month old at the time of application.

Initial application — (severe chronic plaque psoriasis – first-line biologic) only from a dermatologist. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Either:
 - 1.1 Patient has "whole body" severe chronic plaque psoriasis with a Psoriasis Area and Severity Index (PASI) score of

continued...

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

* Three months or six months, as applicable, dispensed all-at-once

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
---	-----	--------------------------	-------------------------------------

continued...

- greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis; or
- 2 Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis; and
 - 2 Patient has tried, but had an inadequate response (see Note) to, or has experienced intolerable side effects from, at least three of the following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, ciclosporin, or acitretin; and
 - 3 A PASI assessment or Dermatology Quality of Life Index (DLQI) assessment has been completed for at least the most recent prior treatment course, preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course; and
 - 4 The most recent PASI or DQI assessment is no more than 1 month old at the time of application.

Note: A treatment course is defined as a minimum of 12 weeks of treatment. "Inadequate response" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 10, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the face, hand or foot, at least 2 of the 3 PASI symptom sub scores for erythema, thickness and scaling are rated as severe or very severe, and the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment.

Renewal — (severe chronic plaque psoriasis – first and second-line biologic) only from a dermatologist or medical practitioner on the recommendation of a dermatologist. Approvals valid for 6 months for applications meeting the following criteria:

- Both:
- 1 Either:
 - 1.1 Patient's PASI score has reduced by 75% or more (PASI 75) as compared to baseline PASI prior to commencing secukinumab; or
 - 1.2 Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing secukinumab; and
 - 2 Secukinumab to be administered at a maximum dose of 300 mg monthly.

SILTUXIMAB – Special Authority see [SA1596 below](#) – Retail pharmacy

Note: Siltuximab is to be administered at doses no greater than 11 mg/kg every 3 weeks.

Inj 100 mg vial	770.57	1	✓ Sylvant
Inj 400 mg vial	3,082.33	1	✓ Sylvant

► [SA1596](#) Special Authority for Subsidy

Initial application only from a haematologist or rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has severe HHV-8 negative idiopathic multicentric Castleman's Disease; and
- 2 Treatment with an adequate trial of corticosteroids has proven ineffective; and
- 3 Siltuximab is to be administered at doses no greater than 11 mg/kg every 3 weeks.

Renewal only from a haematologist or rheumatologist. Approvals valid for 12 months where the treatment remains appropriate and the patient has sustained improvement in inflammatory markers and functional status.

TRASTUZUMAB – PCT only – Specialist – Special Authority see [SA1632 below](#)

Inj 150 mg vial	1,350.00	1	✓ Herceptin
Inj 440 mg vial	3,875.00	1	✓ Herceptin
Inj 1 mg for ECP	9.36	1 mg	✓ Baxter

► [SA1632](#) Special Authority for Subsidy

Initial application — (metastatic breast cancer) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

All of the following:

- 1 The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology); and
- 2 Either:
 - 2.1 The patient has not previously received lapatinib treatment for HER-2 positive metastatic breast cancer; or
 - 2.2 Both:
 - 2.2.1 The patient started lapatinib treatment for metastatic breast cancer but discontinued lapatinib within 3 months of starting treatment due to intolerance; and
 - 2.2.2 The cancer did not progress whilst on lapatinib; and
- 3 Either:
 - 3.1 Trastuzumab will not be given in combination with pertuzumab; or
 - 3.2 All of the following:
 - 3.2.1 Trastuzumab to be administered in combination with pertuzumab; and
 - 3.2.2 Patient has not received prior treatment for their metastatic disease and has had a treatment-free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer; and
 - 3.2.3 The patient has good performance status (ECOG grade 0-1); and
- 4 Trastuzumab not to be given in combination with lapatinib; and
- 5 Trastuzumab to be discontinued at disease progression.

Renewal — (metastatic breast cancer) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology); and
- 2 The cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab; and
- 3 Trastuzumab not to be given in combination with lapatinib; and
- 4 Trastuzumab to be discontinued at disease progression.

Initial application — (early breast cancer) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 15 months for applications meeting the following criteria:

All of the following:

- 1 The patient has early breast cancer expressing HER 2 IHC 3+ or ISH + (including FISH or other current technology); and
- 2 Maximum cumulative dose of 106 mg/kg (12 months' treatment); and
- 3 Any of the following:
 - 3.1 9 weeks' concurrent treatment with adjuvant chemotherapy is planned; or
 - 3.2 12 months' concurrent treatment with adjuvant chemotherapy is planned; or
 - 3.3 12 months' sequential treatment following adjuvant chemotherapy is planned; or
 - 3.4 12 months' treatment with neoadjuvant and adjuvant chemotherapy is planned; or
 - 3.5 Other treatment regimen, in association with adjuvant chemotherapy, is planned.

Renewal — (early breast cancer*) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology); and
- 2 The patient received prior adjuvant trastuzumab treatment for early breast cancer; and
- 3 Any of the following:
 - 3.1 The patient has not previously received lapatinib treatment for HER-2 positive metastatic breast cancer; or
 - 3.2 Both:

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

- 3.2.1 The patient started lapatinib treatment for metastatic breast cancer but discontinued lapatinib within 3 months of starting treatment due to intolerance; and
- 3.2.2 The cancer did not progress whilst on lapatinib; or
- 3.3 The cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab; and
- 4 Either:
 - 4.1 Trastuzumab will not be given in combination with pertuzumab; or
 - 4.2 All of the following:
 - 4.2.1 Trastuzumab to be administered in combination with pertuzumab; and
 - 4.2.2 Patient has not received prior treatment for their metastatic disease and has had a treatment-free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer; and
 - 4.2.3 The patient has good performance status (ECOG grade 0-1); and
- 5 Trastuzumab not to be given in combination with lapatinib; and
- 6 Trastuzumab to be discontinued at disease progression.

Note: * For patients with relapsed HER-2 positive disease who have previously received adjuvant trastuzumab for early breast cancer.

Programmed Cell Death-1 (PD-1) Inhibitors

NIVOLUMAB – PCT only – Specialist – Special Authority see [SA1656](#) below

Inj 10 mg per ml, 4 ml vial.....	1,051.98	1	✓ Opdivo
Inj 10 mg per ml, 10 ml vial.....	2,629.96	1	✓ Opdivo
Inj 1 mg for ECP.....	27.62	1 mg	✓ Baxter

►SA1656 Special Authority for Subsidy

Initial application — (unresectable or metastatic melanoma) only from a medical oncologist. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Patient has metastatic or unresectable melanoma stage III or IV; and
- 2 Patient has measurable disease as defined by the presence of at least one CT or MRI measurable lesion; and
- 3 The patient has ECOG performance score of 0-2; and
- 4 Either:
 - 4.1 Patient has not received funded pembrolizumab; or
 - 4.2 Both:
 - 4.2.1 Patient has received an initial Special Authority approval for pembrolizumab and has discontinued pembrolizumab within 12 weeks of starting treatment due to intolerance; and
 - 4.2.2 The cancer did not progress while the patient was on pembrolizumab; and
- 5 Nivolumab is to be used at a maximum dose of 3 mg/kg every 2 weeks for a maximum of 12 weeks (6 cycles); and
- 6 Baseline measurement of overall tumour burden is documented (see Note); and
- 7 Documentation confirming that the patient has been informed and acknowledges that the initial funded treatment period of nivolumab will not be continued beyond 12 weeks (6 cycles) if their disease progresses during this time.

Renewal — (unresectable or metastatic melanoma) only from a medical oncologist. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Any of the following:
 - 1.1 Patient's disease has had a complete response to treatment according to RECIST criteria (see Note); or
 - 1.2 Patient's disease has had a partial response to treatment according to RECIST criteria (see Note); or
 - 1.3 Patient has stable disease according to RECIST criteria (see Note); and

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

- 2 Response to treatment in target lesions has been determined by radiologic assessment (CT or MRI scan) following the most recent treatment period; and
- 3 No evidence of progressive disease according to RECIST criteria (see Note); and
- 4 The treatment remains clinically appropriate and the patient is benefitting from the treatment; and
- 5 Nivolumab will be used at a maximum dose of 3 mg/kg every 2 weeks for a maximum of 12 weeks (6 cycles).

Notes: Disease responses to be assessed according to the Response Evaluation Criteria in Solid Tumours (RECIST) version 1.1 (Eisenhauer EA, et al. Eur J Cancer 2009;45:228-47). Assessments of overall tumour burden and measurable disease to be undertaken on a minimum of one lesion and maximum of 5 target lesions (maximum two lesions per organ). Target lesions should be selected on the basis of their size (lesions with the longest diameter), be representative of all involved organs, and suitable for reproducible repeated measurements. Target lesion measurements should be assessed using CT or MRI imaging with the same method of assessment and the same technique used to characterise each identified and reported lesion at baseline and every 12 weeks. Response definitions as follows:

- Complete Response: Disappearance of all target lesions. Any pathological lymph nodes (whether target or non-target) must have reduction in short axis to < 10 mm.
- Partial Response: At least a 30% decrease in the sum of diameters of target lesions, taking as reference the baseline sum diameters.
- Progressive Disease: At least a 20% increase in the sum of diameters of target lesions, taking as reference the smallest sum on study (this includes the baseline sum if that is the smallest on study). In addition to the relative increase of 20%, the sum must also demonstrate an absolute increase of at least 5 mm. (Note: the appearance of one or more new lesions is also considered progression).
- Stable Disease: Neither sufficient shrinkage to qualify for partial response nor sufficient increase to qualify for progressive disease.

PEMBROLIZUMAB – PCT only – Specialist – Special Authority see [SA1657 below](#)

Inj 50 mg vial	2,340.00	1	✓ Keytruda
Inj 1 mg for ECP	49.14	1 mg	✓ Baxter

►SA1657 Special Authority for Subsidy

Initial application — (unresectable or metastatic melanoma) only from a medical oncologist. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Patient has metastatic or unresectable melanoma stage III or IV; and
- 2 Patient has measurable disease as defined by the presence of at least one CT or MRI measurable lesion; and
- 3 The patient has ECOG performance score of 0-2; and
- 4 Either:
 - 4.1 Patient has not received funded nivolumab; or
 - 4.2 Both:
 - 4.2.1 Patient has received an initial Special Authority approval for nivolumab and has discontinued nivolumab within 12 weeks of starting treatment due to intolerance; and
 - 4.2.2 The cancer did not progress while the patient was on nivolumab; and
- 5 Pembrolizumab is to be used at a maximum dose of 2 mg/kg every 3 weeks for a maximum of 12 weeks (4 cycles); and
- 6 Baseline measurement of overall tumour burden is documented (see Note); and
- 7 Documentation confirming that the patient has been informed and acknowledges that the initial funded treatment period of pembrolizumab will not be continued beyond 12 weeks (4 cycles) if their disease progresses during this time.

Renewal — (unresectable or metastatic melanoma) only from a medical oncologist. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Any of the following:
 - 1.1 Patient's disease has had a complete response to treatment according to RECIST criteria (see Note); or

continued...

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

- 1.2 Patient's disease has had a partial response to treatment according to RECIST criteria (see Note); or
- 1.3 Patient has stable disease according to RECIST criteria (see Note); and
- 2 Response to treatment in target lesions has been determined by radiologic assessment (CT or MRI scan) following the most recent treatment period; and
- 3 No evidence of progressive disease according to RECIST criteria (see Note); and
- 4 The treatment remains clinically appropriate and the patient is benefitting from the treatment; and
- 5 Pembrolizumab will be used at a maximum dose of 2 mg/kg every 3 weeks for a maximum of 12 weeks (4 cycles).

Notes: Disease responses to be assessed according to the Response Evaluation Criteria in Solid Tumours (RECIST) version 1.1 (Eisenhauer EA, et al. Eur J Cancer 2009;45:228-47). Assessments of overall tumour burden and measurable disease to be undertaken on a minimum of one lesion and maximum of 5 target lesions (maximum two lesions per organ). Target lesions should be selected on the basis of their size (lesions with the longest diameter), be representative of all involved organs, and suitable for reproducible repeated measurements. Target lesion measurements should be assessed using CT or MRI imaging with the same method of assessment and the same technique used to characterise each identified and reported lesion at baseline and every 12 weeks. Response definitions as follows:

- Complete Response: Disappearance of all target lesions. Any pathological lymph nodes (whether target or non-target) must have reduction in short axis to < 10 mm.
- Partial Response: At least a 30% decrease in the sum of diameters of target lesions, taking as reference the baseline sum diameters.
- Progressive Disease: At least a 20% increase in the sum of diameters of target lesions, taking as reference the smallest sum on study (this includes the baseline sum if that is the smallest on study). In addition to the relative increase of 20%, the sum must also demonstrate an absolute increase of at least 5 mm. (Note: the appearance of one or more new lesions is also considered progression).
- Stable Disease: Neither sufficient shrinkage to qualify for partial response nor sufficient increase to qualify for progressive disease.

Other Immunosuppressants

CICLOSPORIN

Cap 25 mg	44.63	50	✓ Neoral
Cap 50 mg	88.91	50	✓ Neoral
Cap 100 mg	177.81	50	✓ Neoral
Oral liq 100 mg per ml	198.13	50 ml OP	✓ Neoral

EVEROLIMUS – Special Authority see [SA1491 below](#) – Retail pharmacy

Wastage claimable			
Tab 10 mg	6,512.29	30	✓ Afinitor
Tab 5 mg	4,555.76	30	✓ Afinitor

► [SA1491](#) Special Authority for Subsidy

Initial application only from a neurologist or oncologist. Approvals valid for 3 months for applications meeting the following criteria:

- Both:
- 1 Patient has tuberous sclerosis; and
 - 2 Patient has progressively enlarging sub-ependymal giant cell astrocytomas (SEGAs) that require treatment.

Renewal only from a neurologist or oncologist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Documented evidence of SEGA reduction or stabilisation by MRI within the last 3 months; and
- 2 The treatment remains appropriate and the patient is benefitting from treatment; and
- 3 Everolimus to be discontinued at progression of SEGAs.

Note: MRI should be performed at minimum once every 12 months, more frequent scanning should be performed with new onset of symptoms such as headaches, visual complaints, nausea or vomiting, or increase in seizure activity.

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
SIROLIMUS – Special Authority see SA0866 below – Retail pharmacy				
Tab 1 mg	749.99	100	✓	Rapamune
Tab 2 mg	1,499.99	100	✓	Rapamune
Oral liq 1 mg per ml	449.99	60 ml OP	✓	Rapamune

» **SA0866** **Special Authority for Subsidy**

Initial application from any medical practitioner. Approvals valid without further renewal unless notified where the drug is to be used for rescue therapy for an organ transplant recipient.

Notes: Rescue therapy defined as unresponsive to calcineurin inhibitor treatment as defined by refractory rejection; or intolerant to calcineurin inhibitor treatment due to any of the following:

- GFR< 30 ml/min; or
- Rapidly progressive transplant vasculopathy; or
- Rapidly progressive obstructive bronchiolitis; or
- HUS or TTP; or
- Leukoencephalopathy; or
- Significant malignant disease

TACROLIMUS – Special Authority see [SA1745 below](#) – Retail pharmacy

Cap 0.5 mg	55.64	100	✓	Tacrolimus Sandoz
Cap 1 mg	111.28	100	✓	Tacrolimus Sandoz
Cap 5 mg	278.20	50	✓	Tacrolimus Sandoz

» **SA1745** **Special Authority for Subsidy**

Initial application — (organ transplant) only from a relevant specialist. Approvals valid without further renewal unless notified where the patient is an organ transplant recipient.

Note: Subsidy applies for either primary or rescue therapy.

Initial application — (non-transplant indications*) only from a relevant specialist. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- 1 Patient requires long-term systemic immunosuppression; and
- 2 Ciclosporin has been trialled and discontinued treatment because of unacceptable side effects or inadequate clinical response.

Note: Indications marked with * are unapproved indications

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

* Three months or six months, as applicable, dispensed all-at-once

Antiallergy Preparations

Allergic Emergencies

ICATIBANT – Special Authority see [SA1558 below](#) – Retail pharmacy

Inj 10 mg per ml, 3 ml prefilled syringe	2,668.00	1	✓ Firazyr
--	----------	---	------------------

► [SA1558](#) **Special Authority for Subsidy**

Initial application only from a clinical immunologist or relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 Supply for anticipated emergency treatment of laryngeal/oro-pharyngeal or severe abdominal attacks of acute hereditary angioedema (HAE) for patients with confirmed diagnosis of C1-esterase inhibitor deficiency; and
- 2 The patient has undergone product training and has agreed upon an action plan for self-administration.

Renewal from any relevant practitioner. Approvals valid for 12 months where the treatment remains appropriate and the patient is benefiting from treatment.

Allergy Desensitisation

► [SA1367](#) **Special Authority for Subsidy**

Initial application only from a relevant specialist. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 RAST or skin test positive; and
- 2 Patient has had severe generalised reaction to the sensitising agent.

Renewal only from a relevant specialist. Approvals valid for 2 years where the treatment remains appropriate and the patient is benefiting from treatment.

BEE VENOM ALLERGY TREATMENT – Special Authority see [SA1367 above](#) – Retail pharmacy

Maintenance kit - 6 vials 120 mcg freeze dried venom, with diluent	285.00	1 OP	✓ Venomil ^{S29}
Treatment kit - 1 vial 550 mcg freeze dried venom, 1 diluent 9 ml, 3 diluent 1.8 ml	305.00	1 OP	✓ Albey
Treatment kit - 1 vial 550 mcg freeze dried venom, with diluent	305.00	1 OP	✓ Hymenoptera ^{S29}

WASP VENOM ALLERGY TREATMENT – Special Authority see [SA1367 above](#) – Retail pharmacy

Treatment kit (Paper wasp venom) - 1 vial 550 mcg freeze dried polister venom, 1 diluent 9 ml, 1 diluent 1.8 ml	305.00	1 OP	✓ Albey
Treatment kit (Paper wasp venom) - 1 vial 550 mcg freeze dried venom, with diluent	305.00	1 OP	✓ Hymenoptera ^{S29}
Treatment kit (Paper wasp venom) - 6 vials 120 mcg freeze dried venom, with diluent	305.00	1 OP	✓ Venomil ^{S29}
Treatment kit (Yellow Jacket venom) - 1 vial 550 mcg freeze dried venom, with diluent	305.00	1 OP	✓ Hymenoptera ^{S29}
Treatment kit (Yellow jacket venom) - 1 vial 550 mcg freeze dried vespula venom, 1 diluent 9 ml, 1 diluent 1.8 ml	305.00	1 OP	✓ Albey
Treatment kit (Yellow jacket venom) - 6 vials 120 mcg freeze dried venom, with diluent	305.00	1 OP	✓ Venomil ^{S29}

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
Antihistamines				
CETIRIZINE HYDROCHLORIDE				
* Tab 10 mg	1.01	100	✓ Zista	
* Oral liq 1 mg per ml	2.99	200 ml	✓ Histaclear	
CHLORPHENIRAMINE MALEATE				
* Oral liq 2 mg per 5 ml	8.06	500 ml	✓ Histafen	
DEXTROCHLORPHENIRAMINE MALEATE				
* Tab 2 mg	2.02	40		
	(8.40)			Polaramine
	1.01	20		
	(5.99)			Polaramine
* Oral liq 2 mg per 5 ml	1.77	100 ml		
	(10.29)			Polaramine
FEXOFENADINE HYDROCHLORIDE				
* Tab 60 mg	4.34	20		
	(8.23)			Telfast
* Tab 120 mg	4.74	10		
	(8.23)			Telfast
	14.22	30		
	(26.44)			Telfast
LORATADINE				
* Tab 10 mg	1.28	100	✓ Lorafix	
* Oral liq 1 mg per ml	2.15	120 ml	✓ Lorfast	
PROMETHAZINE HYDROCHLORIDE				
* Tab 10 mg	1.68	50	✓ Allersoothe	
* Tab 25 mg	1.89	50	✓ Allersoothe	
* Oral liq 1 mg per 1 ml	2.69	100 ml	✓ Allersoothe	
	9.57		✓ Phenergan Elixir	
* Inj 25 mg per ml, 2 ml ampoule – Up to 5 inj available on a PSO	15.54	5	✓ Hospira	
<i>(Phenergan Elixir Oral liq 1 mg per 1 ml to be delisted 1 December 2018)</i>				
TRIMEPRAZINE TARTRATE				
Oral liq 30 mg per 5 ml	2.79	100 ml OP		
	(8.06)			Vallergan Forte
<i>(Vallergan Forte Oral liq 30 mg per 5 ml to be delisted 1 February 2019)</i>				
Inhaled Corticosteroids				
BECLOMETHASONE DIPROPIONATE				
Aerosol inhaler, 50 mcg per dose	9.30	200 dose OP	✓ Qvar	
Aerosol inhaler, 50 mcg per dose CFC-free	8.54	200 dose OP	✓ Beclazone 50	
Aerosol inhaler, 100 mcg per dose	15.50	200 dose OP	✓ Qvar	
Aerosol inhaler, 100 mcg per dose CFC-free	12.50	200 dose OP	✓ Beclazone 100	
Aerosol inhaler, 250 mcg per dose CFC-free	22.67	200 dose OP	✓ Beclazone 250	
BUDESONIDE				
Powder for inhalation, 100 mcg per dose	17.00	200 dose OP	✓ Pulmicort Turbuhaler	
Powder for inhalation, 200 mcg per dose	19.00	200 dose OP	✓ Pulmicort Turbuhaler	
Powder for inhalation, 400 mcg per dose	32.00	200 dose OP	✓ Pulmicort Turbuhaler	

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

* Three months or six months, as applicable, dispensed all-at-once

RESPIRATORY SYSTEM AND ALLERGIES

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
FLUTICASONE				
Aerosol inhaler, 50 mcg per dose.....	4.68	120 dose OP	✓	Floair
Aerosol inhaler, 50 mcg per dose CFC-free	7.50	120 dose OP	✓	Flixotide
Powder for inhalation, 50 mcg per dose.....	7.50	60 dose OP	✓	Flixotide Accuhaler
Powder for inhalation, 100 mcg per dose.....	7.50	60 dose OP	✓	Flixotide Accuhaler
Aerosol inhaler, 125 mcg per dose.....	7.22	120 dose OP	✓	Floair
Aerosol inhaler, 125 mcg per dose CFC-free	13.60	120 dose OP	✓	Flixotide
Aerosol inhaler, 250 mcg per dose.....	10.18	120 dose OP	✓	Floair
Aerosol inhaler, 250 mcg per dose CFC-free	27.20	120 dose OP	✓	Flixotide
Powder for inhalation, 250 mcg per dose	13.60	60 dose OP	✓	Flixotide Accuhaler

Inhaled Long-acting Beta-adrenoceptor Agonists

EFORMOTEROL FUMARATE

Powder for inhalation, 6 mcg per dose, breath activated	10.32 (16.90)	60 dose OP		Oxis Turbuhaler
Powder for inhalation, 12 mcg per dose, and monodose device.....	20.64 (35.80)	60 dose		Foradil

(Oxis Turbuhaler Powder for inhalation, 6 mcg per dose, breath activated to be delisted 1 April 2019)

EFORMOTEROL FUMARATE DIHYDRATE

Powder for inhalation 4.5 mcg per dose, breath activated (equivalent to eformoterol fumarate 6 mcg metered dose).....	10.32 (16.90)	60 dose OP		Oxis Turbuhaler
--	------------------	------------	--	-----------------

INDACATEROL

Powder for inhalation 150 mcg.....	61.00	30 dose OP	✓	Onbrez Breezhaler
Powder for inhalation 300 mcg.....	61.00	30 dose OP	✓	Onbrez Breezhaler

SALMETEROL

Aerosol inhaler CFC-free, 25 mcg per dose	25.00	120 dose OP	✓	Serevent
Aerosol inhaler 25 mcg per dose.....	9.90	120 dose OP	✓	Meterol
Powder for inhalation, 50 mcg per dose, breath activated	25.00	60 dose OP	✓	Serevent Accuhaler

Inhaled Corticosteroids with Long-Acting Beta-Adrenoceptor Agonists

BUDESONIDE WITH EFORMOTEROL

Aerosol inhaler 100 mcg with eformoterol fumarate 6 mcg	18.23	120 dose OP	✓	Vannair
Powder for inhalation 100 mcg with eformoterol fumarate 6 mcg	33.74	120 dose OP	✓	Symbicort Turbuhaler 100/6
Aerosol inhaler 200 mcg with eformoterol fumarate 6 mcg	21.40	120 dose OP	✓	Vannair
Powder for inhalation 200 mcg with eformoterol fumarate 6 mcg	44.08	120 dose OP	✓	Symbicort Turbuhaler 200/6
Powder for inhalation 400 mcg with eformoterol fumarate 12 mcg – No more than 2 dose per day	44.08	60 dose OP	✓	Symbicort Turbuhaler 400/12

FLUTICASONE FUROATE WITH VILANTEROL

Powder for inhalation 100 mcg with vilanterol 25 mcg	44.08	30 dose OP	✓	Breo Ellipta
--	-------	------------	---	---------------------

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
FLUTICASONE WITH SALMETEROL				
Aerosol inhaler 50 mcg with salmeterol 25 mcg	14.58	120 dose OP	✓	RexAir
	33.74		✓	Seretide
Aerosol inhaler 125 mcg with salmeterol 25 mcg	16.83	120 dose OP	✓	RexAir
	44.08		✓	Seretide
Powder for inhalation 100 mcg with salmeterol 50 mcg – No more than 2 dose per day	33.74	60 dose OP	✓	Seretide Accuhaler
Powder for inhalation 250 mcg with salmeterol 50 mcg – No more than 2 dose per day	44.08	60 dose OP	✓	Seretide Accuhaler

Beta-Adrenoceptor Agonists

SALBUTAMOL				
Oral liq 400 mcg per ml	20.00	150 ml	✓	Ventolin
Ventolin to be Sole Supply on 1 December 2018				
Infusion 1 mg per ml, 5 ml	118.38 (130.21)	10		Ventolin
Inj 500 mcg per ml, 1 ml – Up to 5 inj available on a PSO	12.90	5	✓	Ventolin

Inhaled Beta-Adrenoceptor Agonists

SALBUTAMOL				
Aerosol inhaler, 100 mcg per dose CFC free – Up to 1000 dose available on a PSO	3.80 (6.00)	200 dose OP	✓	Respigen SalAir Ventolin
Nebuliser soln, 1 mg per ml, 2.5 ml ampoule – Up to 30 neb available on a PSO	3.93	20	✓	Asthalin
Nebuliser soln, 2 mg per ml, 2.5 ml ampoule – Up to 30 neb available on a PSO	4.03	20	✓	Asthalin
TERBUTALINE SULPHATE				
Powder for inhalation, 250 mcg per dose, breath activated	22.00	200 dose OP	✓	Bricanyl Turbuhaler

Anticholinergic Agents

IPRATROPIUM BROMIDE				
Aerosol inhaler, 20 mcg per dose CFC-free – Up to 400 dose available on a PSO	16.20	200 dose OP	✓	Atrovent
Nebuliser soln, 250 mcg per ml, 1 ml ampoule – Up to 40 neb available on a PSO	3.35	20	✓	Univent
Nebuliser soln, 250 mcg per ml, 2 ml ampoule – Up to 40 neb available on a PSO	3.52	20	✓	Univent

Inhaled Beta-Adrenoceptor Agonists with Anticholinergic Agents

SALBUTAMOL WITH IPRATROPIUM BROMIDE				
Aerosol inhaler, 100 mcg with ipratropium bromide, 20 mcg per dose CFC-free	12.19	200 dose OP	✓	Duolin HFA
Nebuliser soln, 2.5 mg with ipratropium bromide 0.5 mg per vial, 2.5 ml ampoule – Up to 20 neb available on a PSO	5.20	20	✓	Duolin

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
--	---	----------------------------	-------------------------------------

Long-Acting Muscarinic Antagonists

GLYCOPYRRONIUM – Subsidy by endorsement

- Inhaled glycopyrronium treatment will not be subsidised if patient is also receiving treatment with subsidised tiotropium or umeclidinium.
- Glycopyrronium powder for inhalation 50 mcg per dose is subsidised only for patients who have been diagnosed as having COPD using spirometry, and the prescription is endorsed accordingly.

Powder for inhalation 50 mcg per dose 61.00 30 dose OP ✓ **Seebri Breezhaler**

TIOTROPIUM BROMIDE – Subsidy by endorsement

- Tiotropium treatment will not be subsidised if patient is also receiving treatment with subsidised inhaled glycopyrronium or umeclidinium.
- Tiotropium bromide is subsidised only for patients who have been diagnosed as having COPD using spirometry, and the prescription is endorsed accordingly. Patients who had tiotropium dispensed before 1 October 2018 with a valid Special Authority are deemed endorsed.

Powder for inhalation, 18 mcg per dose 50.37 30 dose ✓ **Spiriva**
Soln for inhalation 2.5 mcg per dose 50.37 60 dose OP ✓ **Spiriva Respimat**

UMECLIDINIUM – Subsidy by endorsement

- Umeclidinium will not be subsidised if patient is also receiving treatment with subsidised inhaled glycopyrronium or tiotropium bromide.
- Umeclidinium powder for inhalation 62.5 mcg per dose is subsidised only for patients who have been diagnosed as having COPD using spirometry, and the prescription is endorsed accordingly.

Powder for inhalation 62.5 mcg per dose 61.50 30 dose OP ✓ **Incruse Ellipta**

Long-Acting Muscarinic Antagonists with Long-Acting Beta-Adrenoceptor Agonists

Combination long acting muscarinic antagonist and long acting beta-2 agonist will not be subsidised if patient is also receiving treatment with a combination inhaled corticosteroid and long acting beta-2 agonist.

►SA1584 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

- Both:
- 1 Patient has been stabilised on a long acting muscarinic antagonist; and
 - 2 The prescriber considers that the patient would receive additional benefit from switching to a combination product.

Renewal from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

- Both:
- 1 Patient is compliant with the medication; and
 - 2 Patient has experienced improved COPD symptom control (prescriber determined).

GLYCOPYRRONIUM WITH INDACATEROL – Special Authority see [SA1584 above](#) – Retail pharmacy

Powder for Inhalation 50 mcg with indacaterol 110 mcg 81.00 30 dose OP ✓ **Ultibro Breezhaler**

TIOTROPIUM BROMIDE WITH OLODATEROL – Special Authority see [SA1584 above](#) – Retail pharmacy

Soln for inhalation 2.5 mcg with olodaterol 2.5 mcg 81.00 60 dose OP ✓ **Spiolto Respimat**

UMECLIDINIUM WITH VILANTEROL – Special Authority see [SA1584 above](#) – Retail pharmacy

Powder for inhalation 62.5 mcg with vilanterol 25 mcg 77.00 30 dose OP ✓ **Anoro Ellipta**

Antifibrotics

NINTEDANIB – Special Authority see [SA1755 on the next page](#) – Retail pharmacy

Cap 100 mg 2,554.00 60 OP ✓ **Ofev**
Cap 150 mg 3,870.00 60 OP ✓ **Ofev**

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

►SA1755 Special Authority for Subsidy

Initial application — (idiopathic pulmonary fibrosis) only from a respiratory specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient has been diagnosed with idiopathic pulmonary fibrosis by a multidisciplinary team including a radiologist; and
- 2 Forced vital capacity is between 50% and 90% predicted; and
- 3 Nintedanib is to be discontinued at disease progression (See Note); and
- 4 Nintedanib is not to be used in combination with subsidised pirfenidone; and
- 5 Any of the following:
 - 5.1 The patient has not previously received treatment with pirfenidone; or
 - 5.2 Patient has previously received pirfenidone, but discontinued pirfenidone within 12 weeks due to intolerance; or
 - 5.3 Patient has previously received pirfenidone, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with pirfenidone).

Renewal — (idiopathic pulmonary fibrosis) only from a respiratory specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment; and
- 2 Nintedanib is not to be used in combination with subsidised pirfenidone; and
- 3 Nintedanib is to be discontinued at disease progression (See Note).

Note: disease progression is defined as a decline in percent predicted FVC of 10% or more within any 12 month period.

PIRFENIDONE – Retail pharmacy-Specialist – Special Authority see [SA1748 below](#)

Note: Pirfenidone is not subsidised in combination with subsidised nintedanib.

Cap 267 mg – Wastage claimable.....3,645.00 270 ✓ Esbriet

►SA1748 Special Authority for Subsidy

Initial application — (idiopathic pulmonary fibrosis) only from a respiratory specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient has been diagnosed with idiopathic pulmonary fibrosis by a multidisciplinary team including a radiologist; and
- 2 Forced vital capacity is between 50% and 80% predicted; and
- 3 Pirfenidone is to be discontinued at disease progression (See Note); and
- 4 Pirfenidone is not to be used in combination with subsidised nintedanib; and
- 5 Any of the following:
 - 5.1 The patient has not previously received treatment with nintedanib; or
 - 5.2 Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance; or
 - 5.3 Patient has previously received nintedanib, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with nintedanib).

Renewal — (idiopathic pulmonary fibrosis) only from a respiratory specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment; and
- 2 Pirfenidone is not to be used in combination with subsidised nintedanib; and
- 3 Pirfenidone is to be discontinued at disease progression (See Note).

Note: disease progression is defined as a decline in percent predicted FVC of 10% or more within any 12 month period.

RESPIRATORY SYSTEM AND ALLERGIES

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

Leukotriene Receptor Antagonists

MONTELUKAST

* Tab 4 mg	5.25	28	✓	Apo-Montelukast
* Tab 5 mg	5.50	28	✓	Apo-Montelukast
* Tab 10 mg	5.65	28	✓	Accord <small>\$29</small>
			✓	Apo-Montelukast

Mast Cell Stabilisers

NEDOCROMIL

Aerosol inhaler, 2 mg per dose CFC-free	28.07	112 dose OP	✓	Tilade
---	-------	-------------	---	---------------

SODIUM CROMOGLICATE

Aerosol inhaler, 5 mg per dose CFC-free	28.07	112 dose OP	✓	Intal Forte CFC Free
---	-------	-------------	---	-----------------------------

Methylxanthines

AMINOPHYLLINE

* Inj 25 mg per ml, 10 ml ampoule – Up to 5 inj available on a PSO	124.37	5	✓	DBL Aminophylline
---	--------	---	---	--------------------------

THEOPHYLLINE

* Tab long-acting 250 mg	21.51	100	✓	Nuelin-SR
* Oral liq 80 mg per 15 ml	15.50	500 ml	✓	Nuelin

Mucolytics

DORNASE ALFA – Special Authority see [SA0611 below](#) – Retail pharmacy

Nebuliser soln, 2.5 mg per 2.5 ml ampoule	250.00	6	✓	Pulmozyme
---	--------	---	---	------------------

► [SA0611](#) Special Authority for Subsidy

Special Authority approved by the Cystic Fibrosis Advisory Panel

Notes: Application details may be obtained from PHARMAC's website <http://www.pharmac.govt.nz> or:

The Co-ordinator, Cystic Fibrosis Advisory Panel	Phone: (04) 460 4990
PHARMAC, PO Box 10 254	Facsimile: (04) 916 7571
Wellington	Email: CFPanel@pharmac.govt.nz

Prescriptions for patients approved for treatment must be written by respiratory physicians or paediatricians who have experience and expertise in treating cystic fibrosis.

SODIUM CHLORIDE

Not funded for use as a nasal drop.				
Soln 7%	23.50	90 ml OP	✓	Biomed

Nasal Preparations

Allergy Prophylactics

BECLOMETHASONE DIPROPIONATE

Metered aqueous nasal spray, 50 mcg per dose	2.35	200 dose OP		
	(5.26)			Alanase
Metered aqueous nasal spray, 100 mcg per dose	2.46	200 dose OP		
	(6.00)			Alanase

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
BUDESONIDE				
Metered aqueous nasal spray, 50 mcg per dose	2.59	200 dose OP	✓	SteroClear
	2.35			
	(5.26)			Butacort Aqueous
SteroClear to be Sole Supply on 1 January 2019				
Metered aqueous nasal spray, 100 mcg per dose	2.87	200 dose OP	✓	SteroClear
	2.61			
	(6.00)			Butacort Aqueous
SteroClear to be Sole Supply on 1 January 2019				
<i>(Butacort Aqueous Metered aqueous nasal spray, 50 mcg per dose to be delisted 1 January 2019)</i>				
<i>(Butacort Aqueous Metered aqueous nasal spray, 100 mcg per dose to be delisted 1 January 2019)</i>				
FLUTICASONE PROPIONATE				
Metered aqueous nasal spray, 50 mcg per dose	1.98	120 dose OP	✓	Flixonase Hayfever & Allergy
Flixonase Hayfever & Allergy to be Sole Supply on 1 December 2018				
IPRATROPIUM BROMIDE				
Aqueous nasal spray, 0.03%.....	4.61	15 ml OP	✓	Univent

Respiratory Devices

MASK FOR SPACER DEVICE

a) Up to 50 dev available on a PSO				
b) Only on a PSO				
c) Only for children aged six years and under				
Small.....	2.20	1	✓	e-chamber Mask

PEAK FLOW METER

a) Up to 25 dev available on a PSO				
b) Only on a PSO				
Low range.....	9.54	1	✓	Mini-Wright AFS Low Range
Normal range.....	9.54	1	✓	Mini-Wright Standard

SPACER DEVICE

a) Up to 50 dev available on a PSO				
b) Only on a PSO				
220 ml (single patient)	2.95	1	✓	e-chamber Turbo
510 ml (single patient)	5.12	1	✓	e-chamber La Grande
800 ml.....	6.50	1	✓	Volumatic

Respiratory Stimulants

CAFFEINE CITRATE

Oral liq 20 mg per ml (10 mg base per ml)	14.85	25 ml OP	✓	Biomed
---	-------	----------	---	---------------

Ear Preparations

ACETIC ACID WITH 1, 2- PROPANEDIOL DIACETATE AND BENZETHONIUM

For Vosol ear drops with hydrocortisone powder refer Standard Formulae, [page 215](#)

Ear drops 2% with 1, 2-Propanediol diacetate 3% and

benzethonium chloride 0.02%6.97 35 ml OP ✓ **Vosol**

FLUMETASONE PIVALATE

Ear drops 0.02% with clioquinol 1%4.46 7.5 ml OP ✓ **Locacorten-Viaform ED's**

✓ **Locorten-Vioform**

TRIAMCINOLONE ACETONIDE WITH GRAMICIDIN, NEOMYCIN AND NYSTATIN

Ear drops 1 mg with nystatin 100,000 u, neomycin sulphate

2.5 mg and gramicidin 250 mcg per g5.16 7.5 ml OP ✓ **Kenacomb**

Ear/Eye Preparations

DEXAMETHASONE WITH FRAMYCETIN AND GRAMICIDIN

Ear/Eye drops 500 mcg with framycetin sulphate 5 mg and

gramicidin 50 mcg per ml4.50 8 ml OP
(9.27) Sofradex

FRAMYCETIN SULPHATE

Ear/Eye drops 0.5%.....4.13 8 ml OP
(8.65) Soframycin

Eye Preparations

Eye preparations are only funded for use in the eye, unless explicitly stated otherwise.

Anti-Infective Preparations

ACICLOVIR

* Eye oint 3%14.92 4.5 g OP ✓ **ViruPOS**

CHLORAMPHENICOL

Eye oint 1%2.48 4 g OP ✓ **Chlorsig**

Eye drops 0.5%0.98 10 ml OP ✓ **Chlorafast**

Funded for use in the ear*. Indications marked with * are unapproved indications.

CIPROFLOXACIN

Eye drops 0.3% – Subsidy by endorsement.....9.99 5 ml OP ✓ **Ciprofloxacin Teva**

When prescribed for the treatment of bacterial keratitis or severe bacterial conjunctivitis resistant to chloramphenicol; or for the second line treatment of chronic suppurative otitis media (CSOM)*; and the prescription is endorsed accordingly.

Note: Indication marked with a * is an unapproved indication.

GENTAMICIN SULPHATE

Eye drops 0.3%11.40 5 ml OP ✓ **Genoptic**

PROPAMIDINE ISETHIONATE

* Eye drops 0.1%2.97 10 ml OP
(14.55) Brolene

SODIUM FUSIDATE [FUSIDIC ACID]

Eye drops 1%5.29 5 g OP ✓ **Fucithalmic**

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
TOBRAMYCIN				
Eye oint 0.3%	10.45	3.5 g OP	✓	Tobrex
Eye drops 0.3%	11.48	5 ml OP	✓	Tobrex

Corticosteroids and Other Anti-Inflammatory Preparations

DEXAMETHASONE

* Eye oint 0.1%	5.86	3.5 g OP	✓	Maxidex
* Eye drops 0.1%	4.50	5 ml OP	✓	Maxidex
Ocular implant 700 mcg – Special Authority see SA1680 below				
– Retail pharmacy.....	1,444.50	1	✓	Ozurdex

►SA1680 Special Authority for Subsidy

Initial application — (Diabetic macular oedema) only from an ophthalmologist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient has diabetic macular oedema with pseudophakic lens; and
- 2 Patient has reduced visual acuity of between 6/9 - 6/48 with functional awareness of reduction in vision; and
- 3 Either:
 - 3.1 Patient's disease has progressed despite 3 injections with bevacizumab; or
 - 3.2 Patient is unsuitable or contraindicated to treatment with anti-VEGF agents; and
- 4 Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year.

Renewal — (Diabetic macular oedema) only from an ophthalmologist. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 Patient's vision is stable or has improved (prescriber determined); and
- 2 Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year.

Initial application — (Women of child bearing age with diabetic macular oedema) only from an ophthalmologist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient has diabetic macular oedema; and
- 2 Patient has reduced visual acuity of between 6/9 - 6/48 with functional awareness of reduction in vision; and
- 3 Patient is of child bearing potential and has not yet completed a family; and
- 4 Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year.

Renewal — (Women of child bearing age with diabetic macular oedema) only from an ophthalmologist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient's vision is stable or has improved (prescriber determined); and
- 2 Patient is of child bearing potential and has not yet completed a family; and
- 3 Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year.

DEXAMETHASONE WITH NEOMYCIN SULPHATE AND POLYMYXIN B SULPHATE

* Eye oint 0.1% with neomycin sulphate 0.35% and polymyxin b sulphate 6,000 u per g.....	5.39	3.5 g OP	✓	Maxitrol
* Eye drops 0.1% with neomycin sulphate 0.35% and polymyxin b sulphate 6,000 u per ml	4.50	5 ml OP	✓	Maxitrol

DICLOFENAC SODIUM

* Eye drops 0.1%	13.80	5 ml OP	✓	Voltaren Ophtha
------------------------	-------	---------	---	------------------------

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

SENSORY ORGANS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
FLUOROMETHOLONE				
* Eye drops 0.1%	3.09	5 ml OP	✓	FML
LEVOCABASTINE				
Eye drops 0.5 mg per ml	8.71 (10.34)	4 ml OP		Livostin
LODOXAMIDE				
Eye drops 0.1%	8.71	10 ml OP	✓	Lomide
PREDNISOLONE ACETATE				
Eye drops 1%	3.93 7.00	10 ml OP 5 ml OP	✓	Prednisolone-AFT Pred Forte
PREDNISOLONE SODIUM PHOSPHATE – Special Authority see SA1715 below – Retail pharmacy				
Eye drops 0.5%, single dose (preservative free)	38.50	20 dose	✓	Minims Prednisolone

► [SA1715](#) Special Authority for Subsidy

Initial application only from an ophthalmologist or optometrist. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Patient has severe inflammation; and
- 2 Patient has a confirmed allergic reaction to preservative in eye drops.

Renewal from any relevant practitioner. Approvals valid for 6 months where the treatment remains appropriate and the patient is benefiting from treatment.

SODIUM CROMOGLICATE

Eye drops 2%	0.85	5 ml OP	✓	Rexacrom
--------------------	------	---------	---	-----------------

Glaucoma Preparations - Beta Blockers

BETAXOLOL

* Eye drops 0.25%	11.80	5 ml OP	✓	Betoptic S
* Eye drops 0.5%	7.50	5 ml OP	✓	Betoptic

LEVOBUNOLOL

* Eye drops 0.5%	7.00	5 ml OP	✓	Betagan
------------------------	------	---------	---	----------------

TIMOLOL

* Eye drops 0.25%	1.43	5 ml OP	✓	Arrow-Timolol
* Eye drops 0.25%, gel forming	3.30	2.5 ml OP	✓	Timoptol XE
* Eye drops 0.5%	1.43	5 ml OP	✓	Arrow-Timolol
* Eye drops 0.5%, gel forming	3.78	2.5 ml OP	✓	Timoptol XE

Glaucoma Preparations - Carbonic Anhydrase Inhibitors

ACETAZOLAMIDE

* Tab 250 mg	17.03	100	✓	Diamox
--------------------	-------	-----	---	---------------

BRINZOLAMIDE

* Eye drops 1%	9.77	5 ml OP	✓	Azopt
----------------------	------	---------	---	--------------

DORZOLAMIDE HYDROCHLORIDE

* Eye drops 2%	9.77 (17.44)	5 ml OP		Trusopt
----------------------	-----------------	---------	--	---------

DORZOLAMIDE WITH TIMOLOL

* Eye drops 2% with timolol 0.5%	2.87 3.45	5 ml OP	✓	Dortimopt Arrow-Dortim
--	--------------	---------	---	---

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
--	---	----------------------------	-------------------------------------

Glaucoma Preparations - Prostaglandin Analogues

BIMATOPROST			
* Eye drops 0.03%	3.65	3 ml OP	✓ Bimatoprost Actavis
LATANOPROST			
* Eye drops 0.005%	1.50	2.5 ml OP	✓ Hysite
TRAVOPROST			
* Eye drops 0.004%	7.30	5 ml OP	✓ Travopt
	19.50	2.5 ml OP	✓ Travatan

Glaucoma Preparations - Other

BRIMONIDINE TARTRATE			
* Eye drops 0.2%	4.29	5 ml OP	✓ Arrow-Brimonidine
BRIMONIDINE TARTRATE WITH TIMOLOL MALEATE			
* Eye drops 0.2% with timolol maleate 0.5%	18.50	5 ml OP	✓ Combigan
PILOCARPINE HYDROCHLORIDE			
* Eye drops 1%	4.26	15 ml OP	✓ Isopto Carpine
* Eye drops 2%	5.35	15 ml OP	✓ Isopto Carpine
* Eye drops 4%	7.99	15 ml OP	✓ Isopto Carpine
Subsidised for oral use pursuant to the Standard Formulae.			
* Eye drops 2% single dose – Special Authority see SA0895 below – Retail pharmacy	31.95	20 dose	✓ Minims Pilocarpine

➔ [SA0895](#) Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:
Either:

- 1 Patient has to use an unpreserved solution due to an allergy to the preservative; or
- 2 Patient wears soft contact lenses.

Note: Minims for a general practice are considered to be “tools of trade” and are not approved as special authority items.

Renewal from any relevant practitioner. Approvals valid for 2 years where the treatment remains appropriate and the patient is benefiting from treatment.

Mydriatics and Cycloplegics

ATROPINE SULPHATE			
* Eye drops 1%	17.36	15 ml OP	✓ Atropt
CYCLOPENTOLATE HYDROCHLORIDE			
* Eye drops 1%	8.76	15 ml OP	✓ Cyclogyl
TROPICAMIDE			
* Eye drops 0.5%	7.15	15 ml OP	✓ Mydriacyl
* Eye drops 1%	8.66	15 ml OP	✓ Mydriacyl

Preparations for Tear Deficiency

For acetylcysteine eye drops refer Standard Formulae, [page 215](#)

HYPROMELLOSE			
* Eye drops 0.5%	2.00 (3.92)	15 ml OP	Methopt
HYPROMELLOSE WITH DEXTRAN			
* Eye drops 0.3% with dextran 0.1%	2.30	15 ml OP	✓ Poly-Tears

▲ Three months supply may be dispensed at one time if endorsed “certified exemption” by the prescriber or pharmacist.

* Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
POLYVINYL ALCOHOL				
* Eye drops 1.4%	2.62	15 ml OP	✓	Vistil
* Eye drops 3%	3.68	15 ml OP	✓	Vistil Forte

Preservative Free Ocular Lubricants

►SA1388 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:
Both:

- 1 Confirmed diagnosis by slit lamp of severe secretory dry eye; and
- 2 Either:
 - 2.1 Patient is using eye drops more than four times daily on a regular basis; or
 - 2.2 Patient has had a confirmed allergic reaction to preservative in eye drop.

Renewal from any relevant practitioner. Approvals valid for 24 months where the patient continues to require lubricating eye drops and has benefited from treatment.

CARBOMER – Special Authority see [SA1388 above](#) – Retail pharmacy

Ophthalmic gel 0.3%, 0.5 g8.25 30 ✓ **Poly-Gel**

MACROGOL 400 AND PROPYLENE GLYCOL – Special Authority see [SA1388 above](#) – Retail pharmacy

Eye drops 0.4% and propylene glycol 0.3%, 0.4 ml4.30 24 ✓ **Systane Unit Dose**

SODIUM HYALURONATE [HYALURONIC ACID] – Special Authority see [SA1388 above](#) – Retail pharmacy

Eye drops 1 mg per ml22.00 10 ml OP ✓ **Hylo-Fresh**

Hylo-Fresh has a 6 month expiry after opening. The Pharmacy Procedures Manual restriction allowing one bottle per month is not relevant and therefore only the prescribed dosage to the nearest OP may be claimed.

Other Eye Preparations

NAPHAZOLINE HYDROCHLORIDE

* Eye drops 0.1%4.15 15 ml OP ✓ **Naphcon Forte**

OLOPATADINE

Eye drops 0.1%10.00 5 ml OP ✓ **Patanol**

PARAFFIN LIQUID WITH SOFT WHITE PARAFFIN

* Eye oint with soft white paraffin3.63 3.5 g OP ✓ **Refresh Night Time**

PARAFFIN LIQUID WITH WOOL FAT

* Eye oint 3% with wool fat 3%3.63 3.5 g OP ✓ **Poly-Visc**

RETINOL PALMITATE

Eye oint 138 mcg per g3.80 5 g OP ✓ **VitA-POS**

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

Various

PHARMACY SERVICES

May only be claimed once per patient.

* Brand switch fee	4.50	1 fee	✓ BSF Apo-Gabapentin
			✓ BSF Aripiprazole Sandoz
			✓ BSF Tenofovir Disproxil Teva
a) The Pharmacode for BSF Aripiprazole Sandoz is 2556634 - see also page 135			
b) The Pharmacode for BSF Tenofovir Disproxil Teva is 2556642 - see also page 103			
c) The Pharmacode for BSF Apo-Gabapentin is 2556626 - see also page 130			

(BSF Apo-Gabapentin Brand switch fee to be delisted 1 February 2019)

(BSF Aripiprazole Sandoz Brand switch fee to be delisted 1 February 2019)

(BSF Tenofovir Disproxil Teva Brand switch fee to be delisted 1 February 2019)

Agents Used in the Treatment of Poisonings

Antidotes

ACETYLCYSTEINE – Retail pharmacy-Specialist

Inj 200 mg per ml, 10 ml ampoule	58.76	10	✓ <u>DBL Acetylcysteine</u>
--	-------	----	-----------------------------

NALOXONE HYDROCHLORIDE

a) Up to 5 inj available on a PSO

b) Only on a PSO

* Inj 400 mcg per ml, 1 ml ampoule	22.60	5	✓ <u>DBL Naloxone Hydrochloride</u>
--	-------	---	---

Removal and Elimination

CHARCOAL

* Oral liq 50 g per 250 ml	43.50	250 ml OP	✓ Carbosorb-X
a) Up to 250 ml available on a PSO			
b) Only on a PSO			

DEFERASIROX – Special Authority see [SA1492 below](#) – Retail pharmacy

Wastage claimable

Tab 125 mg dispersible	276.00	28	✓ Exjade
Tab 250 mg dispersible	552.00	28	✓ Exjade
Tab 500 mg dispersible	1,105.00	28	✓ Exjade

►SA1492 Special Authority for Subsidy

Initial application only from a haematologist. Approvals valid for 2 years for applications meeting the following criteria:

All of the following:

- 1 The patient has been diagnosed with chronic iron overload due to congenital inherited anaemia; and
- 2 Deferasirox is to be given at a daily dose not exceeding 40 mg/kg/day; and
- 3 Any of the following:
 - 3.1 Treatment with maximum tolerated doses of deferiprone monotherapy or deferiprone and desferrioxamine combination therapy have proven ineffective as measured by serum ferritin levels, liver or cardiac MRI T2*; or

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

- 3.2 Treatment with deferiprone has resulted in severe persistent vomiting or diarrhoea; or
- 3.3 Treatment with deferiprone has resulted in arthritis; or
- 3.4 Treatment with deferiprone is contraindicated due to a history of agranulocytosis (defined as an absolute neutrophil count (ANC) of < 0.5 cells per μL) or recurrent episodes (greater than 2 episodes) of moderate neutropenia (ANC 0.5 - 1.0 cells per μL).

Renewal only from a haematologist. Approvals valid for 2 years for applications meeting the following criteria:

Either:

- 1 For the first renewal following 2 years of therapy, the treatment has been tolerated and has resulted in clinical improvement in all three parameters namely serum ferritin, cardiac MRI T2* and liver MRI T2* levels; or
- 2 For subsequent renewals, the treatment has been tolerated and has resulted in clinical stability or continued improvement in all three parameters namely serum ferritin, cardiac MRI T2* and liver MRI T2* levels.

DEFERIPRONE – Special Authority see [SA1480 below](#) – Retail pharmacy

Tab 500 mg	533.17	100	✓ Feriprox
Oral liq 100 mg per 1 ml	266.59	250 ml OP	✓ Feriprox

➔ **SA1480 Special Authority for Subsidy**

Initial application only from a haematologist. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Either:

- 1 The patient has been diagnosed with chronic iron overload due to congenital inherited anaemia; or
- 2 The patient has been diagnosed with chronic iron overload due to acquired red cell aplasia.

DESFERRIOXAMINE MESILATE

* Inj 500 mg vial	51.52	10	✓ Desferal
-------------------------	-------	----	-------------------

SODIUM CALCIUM EDETATE

* Inj 200 mg per ml, 5 ml	53.31 (156.71)	6	Calcium Disodium Versenate
---------------------------------	-------------------	---	-------------------------------

Standard Formulae

ACETYL CYSTEINE EYE DROPS

Acetylcysteine inj 200 mg per ml, 10 ml	qs
Suitable eye drop base	qs

PHENOBARBITONE ORAL LIQUID

Phenobarbitone Sodium	1 g
Glycerol BP	70 ml
Water	to 100 ml

ASPIRIN AND CHLOROFORM APPLICATION

Aspirin Soluble tabs 300 mg	12 tabs
Chloroform	to 100 ml

PHENOBARBITONE SODIUM PAEDIATRIC ORAL LIQUID (10 mg per ml)

Phenobarbitone Sodium	400 mg
Glycerol BP	4 ml
Water	to 40 ml

CODEINE LINCTUS PAEDIATRIC (3 mg per 5 ml)

Codeine phosphate	60 mg
Glycerol	40 ml
Preservative	qs
Water	to 100 ml

PILOCARPINE ORAL LIQUID

Pilocarpine 4% eye drops	qs
Preservative	qs
Water	to 500 ml

CODEINE LINCTUS DIABETIC (15 mg per 5 ml)

Codeine phosphate	300 mg
Glycerol	40 ml
Preservative	qs
Water	to 100 ml

(Preservative should be used if quantity supplied is for more than 5 days.)

FOLINIC MOUTHWASH

Calcium folinate 15 mg tab	1 tab
Preservative	qs
Water	to 500 ml

(Preservative should be used if quantity supplied is for more than 5 days. Maximum 500 ml per prescription.)

SALIVA SUBSTITUTE FORMULA

Methylcellulose	5 g
Preservative	qs
Water	to 500 ml

(Preservative should be used if quantity supplied is for more than 5 days. Maximum 500 ml per prescription.)

MAGNESIUM HYDROXIDE 8% MIXTURE

Magnesium hydroxide paste 29%	275 g
Methyl hydroxybenzoate	1.5 g
Water	to 1,000 ml

SODIUM CHLORIDE ORAL LIQUID

Sodium chloride inj 23.4%, 20 ml	qs
Water	qs

(Only funded if prescribed for treatment of hyponatraemia)

METHADONE MIXTURE

Methadone powder	qs
Glycerol	qs
Water	to 100 ml

VANCOMYCIN ORAL SOLUTION (50 mg per ml)

Vancomycin 500 mg injection	10 vials
Glycerol BP	40 ml
Water	to 100 ml

(Only funded if prescribed for treatment of Clostridium difficile following metronidazole failure)

METHYL HYDROXYBENZOATE 10% SOLUTION

Methyl hydroxybenzoate	10 g
Propylene glycol	to 100 ml

(Use 1 ml of the 10% solution per 100 ml of oral liquid mixture)

VOSOL EAR DROPS

WITH HYDROCORTISONE POWDER 1%

Hydrocortisone powder	1%
Vosol Ear Drops	to 35 ml

OMEPRAZOLE SUSPENSION

Omeprazole capules or powder	qs
Sodium bicarbonate powder BP	8.4 g
Water	to 100 ml

EXTEMPORANEOUSLY COMPOUNDED PREPARATIONS AND GALENICALS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
Extemporaneously Compounded Preparations and Galenicals				
BENZOIN				
Tincture compound BP	24.42 (39.90) 2.44 (5.10)	500 ml 50 ml		Pharmacy Health Pharmacy Health
CHLOROFORM				
a) Only in combination				
b) Maximum of 100 ml per prescription				
c) Only in aspirin and chloroform application.				
Chloroform BP	25.50	500 ml	✓ PSM	
CODEINE PHOSPHATE – Safety medicine; prescriber may determine dispensing frequency				
Powder – Only in combination.....	63.09 (90.09)	25 g		Douglas
Only in extemporaneously compounded codeine linctus diabetic or codeine linctus paediatric.				
COLLODION FLEXIBLE				
Collodion flexible	19.30	100 ml	✓ PSM	
COMPOUND HYDROXYBENZOATE – Only in combination				
Only in extemporaneously compounded oral mixtures.				
Soln	30.00 34.18	100 ml	✓ Midwest ✓ David Craig	
GLYCERIN WITH SODIUM SACCHARIN – Only in combination				
Only in combination with Ora-Plus.				
Suspension.....	32.50	473 ml	✓ Ora-Sweet SF	
GLYCERIN WITH SUCROSE – Only in combination				
Only in combination with Ora-Plus.				
Suspension.....	32.50	473 ml	✓ Ora-Sweet	
GLYCEROL				
* Liquid – Only in combination	3.28	500 ml	✓ <u>healthE Glycerol BP</u>	
Only in extemporaneously compounded oral liquid preparations.				
MAGNESIUM HYDROXIDE				
Paste 29%	22.61	500 g	✓ PSM	
METHADONE HYDROCHLORIDE				
a) Only on a controlled drug form				
b) No patient co-payment payable				
c) Safety medicine; prescriber may determine dispensing frequency				
d) Extemporaneously compounded methadone will only be reimbursed at the rate of the cheapest form available (methadone powder, not methadone tablets).				
Powder	7.84	1 g	✓ AFT	
METHYL HYDROXYBENZOATE				
Powder	8.00 8.98	25 g	✓ PSM ✓ Midwest	
<i>(PSM Powder to be delisted 1 January 2019)</i>				
METHYLCELLULOSE				
Powder	36.95	100 g	✓ MidWest	
Suspension – Only in combination.....	32.50	473 ml	✓ Ora-Plus	
METHYLCELLULOSE WITH GLYCERIN AND SODIUM SACCHARIN – Only in combination				
Suspension.....	32.50	473 ml	✓ Ora-Blend SF	

EXTEMPORANEOUSLY COMPOUNDED PREPARATIONS AND GALENICALS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
METHYLCELLULOSE WITH GLYCERIN AND SUCROSE – Only in combination				
Suspension.....	32.50	473 ml	✓	Ora-Blend
PHENOBARBITONE SODIUM				
Powder – Only in combination.....	52.50	10 g	✓	MidWest
	325.00	100 g	✓	MidWest
Only in children up to 12 years				
PROPYLENE GLYCOL				
Only in extemporaneously compounded methyl hydroxybenzoate 10% solution.				
Liq.....	11.25	500 ml	✓	Midwest
SODIUM BICARBONATE				
Powder BP – Only in combination.....	8.95	500 g	✓	Midwest
	9.80			
	(29.50)			David Craig
Only in extemporaneously compounded omeprazole and lansoprazole suspension.				
SYRUP (PHARMACEUTICAL GRADE) – Only in combination				
Only in extemporaneously compounded oral liquid preparations.				
Liq.....	21.75	2,000 ml	✓	Midwest
WATER				
Tap – Only in combination.....	0.00	1 ml	✓	Tap water

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

Nutrient Modules

Carbohydrate

»SA1522 Special Authority for Subsidy

Initial application — (Cystic fibrosis or kidney disease) only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years for applications meeting the following criteria:

- Either:
- 1 cystic fibrosis; or
 - 2 chronic kidney disease.

Initial application — (Indications other than cystic fibrosis or renal failure) only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

- Any of the following:
- 1 cancer in children; or
 - 2 cancers affecting alimentary tract where there are malabsorption problems in patients over the age of 20 years; or
 - 3 faltering growth in an infant/child; or
 - 4 bronchopulmonary dysplasia; or
 - 5 premature and post premature infant; or
 - 6 inborn errors of metabolism; or
 - 7 for use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk.

Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

Renewal — (Cystic fibrosis or renal failure) only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years for applications meeting the following criteria:

- Both:
- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
 - 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

Renewal — (Indications other than cystic fibrosis or renal failure) only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

- Both:
- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
 - 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

CARBOHYDRATE SUPPLEMENT – Special Authority see SA1522 above – Hospital pharmacy [HP3]
Powder5.29 400 g OP ✓ Polycal

Carbohydrate And Fat

»SA1376 Special Authority for Subsidy

Initial application — (Cystic fibrosis) only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years for applications meeting the following criteria:

Both:

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

- 1 Infant or child aged four years or under; and
- 2 cystic fibrosis.

Initial application — (Indications other than cystic fibrosis) only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Both:

- 1 infant or child aged four years or under; and
- 2 Any of the following:
 - 2.1 cancer in children; or
 - 2.2 faltering growth; or
 - 2.3 bronchopulmonary dysplasia; or
 - 2.4 premature and post premature infants.

Renewal — (Cystic fibrosis) only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

Renewal — (Indications other than cystic fibrosis) only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

CARBOHYDRATE AND FAT SUPPLEMENT – Special Authority see [SA1376 on the previous page](#) – Hospital pharmacy [HP3]

Powder (neutral)	60.31	400 g OP	✓ Duocal Super Soluble Powder
------------------------	-------	----------	-------------------------------

Fat

»SA1523 Special Authority for Subsidy

Initial application — (Inborn errors of metabolism) only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years where the patient has inborn errors of metabolism.

Initial application — (Indications other than inborn errors of metabolism) only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Any of the following:

- 1 faltering growth in an infant/child; or
- 2 bronchopulmonary dysplasia; or
- 3 fat malabsorption; or
- 4 lymphangiectasia; or
- 5 short bowel syndrome; or
- 6 infants with necrotising enterocolitis; or
- 7 biliary atresia; or
- 8 for use in a ketogenic diet; or
- 9 chyle leak; or

continued...

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
---	-----	--------------------------	-------------------------------------

continued...

- 10 ascites; or
- 11 for use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk.

Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

Renewal — (Inborn errors of metabolism) only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner.

Approvals valid for 3 years for applications meeting the following criteria:

- Both:
- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
 - 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

Renewal — (Indications other than inborn errors of metabolism) only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

- Both:
- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
 - 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

FAT SUPPLEMENT – Special Authority see [SA1523 on the previous page](#) – Hospital pharmacy [HP3]

Emulsion (neutral)	12.30	200 ml OP	✓ Calogen
	30.75	500 ml OP	✓ Calogen
Emulsion (strawberry).....	12.30	200 ml OP	✓ Calogen
Oil	30.00	500 ml OP	✓ MCT oil (Nutricia)
Oil, 250 ml	114.92	4 OP	✓ Liquigen

Protein

►SA1524 Special Authority for Subsidy

Initial application only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Any of the following:

- 1 protein losing enteropathy; or
- 2 high protein needs; or
- 3 for use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk.

Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

Renewal only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

- Both:
- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
 - 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

PROTEIN SUPPLEMENT – Special Authority see [SA1524 above](#) – Hospital pharmacy [HP3]

Powder	7.90	225 g OP	✓ Protifar
	8.95	227 g OP	✓ Resource Beneprotein

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
	✓	

Oral Supplements/Complete Diet (Nasogastric/Gastrostomy Tube Feed)

Respiratory Products

►SA1094 Special Authority for Subsidy

Initial application only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year where the patient has CORD and hypercapnia, defined as a CO₂ value exceeding 55 mmHg.

Renewal only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

CORD ORAL FEED 1.5KCAL/ML – Special Authority see [SA1094 above](#) – Hospital pharmacy [HP3]

Liquid	1.66	237 ml OP	✓ Pulmocare
--------------	------	-----------	-------------

Diabetic Products

►SA1095 Special Authority for Subsidy

Initial application only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year where the patient is a type I or and II diabetic who is suffering weight loss and malnutrition that requires nutritional support.

Renewal only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

DIABETIC ENTERAL FEED 1KCAL/ML – Special Authority see [SA1095 above](#) – Hospital pharmacy [HP3]

Liquid	7.50	1,000 ml OP	✓ Diason RTH
			✓ Glucerna Select RTH

DIABETIC ORAL FEED 1KCAL/ML – Special Authority see [SA1095 above](#) – Hospital pharmacy [HP3]

Liquid (strawberry)	1.50	200 ml OP	✓ Diasip
Liquid (vanilla)	1.50	200 ml OP	✓ Diasip
	1.88	250 ml OP	✓ Glucerna Select
	1.78	237 ml OP	
	(2.10)		Resource Diabetic
	(2.10)		Sustagen Diabetic

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
--	---	------------------------------	-------------------------------------

Fat Modified Products

»SA1525 Special Authority for Subsidy

Initial application only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:
Any of the following:

- 1 Patient has metabolic disorders of fat metabolism; or
- 2 Patient has a chyle leak; or
- 3 Modified as a modular feed, made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule, for adults.

Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

Renewal only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

- Both:
- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
 - 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

FAT MODIFIED FEED – Special Authority see [SA1525 above](#) – Hospital pharmacy [HP3]
Powder 60.48 400 g OP ✓ **Monogen**

Paediatric Products For Children Awaiting Liver Transplant

»SA1098 Special Authority for Subsidy

Initial application only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years where the patient is a child (up to 18 years) who requires a liver transplant.

Renewal only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years for applications meeting the following criteria:

- Both:
- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
 - 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

ENTERAL/ORAL FEED 1KCAL/ML – Special Authority see [SA1098 above](#) – Hospital pharmacy [HP3]
Powder (unflavoured) 78.97 400 g OP ✓ **Heparon Junior**

Paediatric Products For Children With Chronic Renal Failure

»SA1099 Special Authority for Subsidy

Initial application only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years where the patient is a child (up to 18 years) with acute or chronic kidney disease.

Renewal only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years for applications meeting the following criteria:

- Both:
- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
 - 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
ENTERAL/ORAL FEED 1KCAL/ML – Special Authority see SA1099 on the previous page – Hospital pharmacy [HP3]			
Liquid	54.00	400 g OP	✓ Kindergen

Paediatric Products

► **SA1379** Special Authority for Subsidy

Initial application only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Both:

- 1 Child is aged one to ten years; and
- 2 Any of the following:
 - 2.1 the child is being fed via a tube or a tube is to be inserted for the purposes of feeding; or
 - 2.2 any condition causing malabsorption; or
 - 2.3 faltering growth in an infant/child; or
 - 2.4 increased nutritional requirements; or
 - 2.5 the child is being transitioned from TPN or tube feeding to oral feeding.

Renewal only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

PAEDIATRIC ENTERAL FEED 1.5KCAL/ML – Special Authority see SA1379 above – Hospital pharmacy [HP3]			
Liquid	6.00	500 ml OP	✓ Nutrini Energy RTH
PAEDIATRIC ENTERAL FEED 1KCAL/ML – Special Authority see SA1379 above – Hospital pharmacy [HP3]			
Liquid	2.68	500 ml OP	✓ Nutrini RTH ✓ Pediasure RTH
PAEDIATRIC ENTERAL FEED WITH FIBRE 1.5KCAL/ML – Special Authority see SA1379 above – Hospital pharmacy [HP3]			
Liquid	6.00	500 ml OP	✓ Nutrini Energy Multi Fibre
PAEDIATRIC ORAL FEED 1.5KCAL/ML – Special Authority see SA1379 above – Hospital pharmacy [HP3]			
Liquid (strawberry)	1.60	200 ml OP	✓ Fortini
Liquid (vanilla)	1.60	200 ml OP	✓ Fortini
PAEDIATRIC ORAL FEED 1KCAL/ML – Special Authority see SA1379 above – Hospital pharmacy [HP3]			
Liquid (chocolate)	1.07	200 ml OP	✓ Pediasure
Liquid (strawberry)	1.07	200 ml OP	✓ Pediasure
Liquid (vanilla)	1.07	200 ml OP	✓ Pediasure
	1.34	250 ml OP	✓ Pediasure
PAEDIATRIC ORAL FEED WITH FIBRE 1.5KCAL/ML – Special Authority see SA1379 above – Hospital pharmacy [HP3]			
Liquid (chocolate)	1.60	200 ml OP	✓ Fortini Multi Fibre
Liquid (strawberry)	1.60	200 ml OP	✓ Fortini Multi Fibre
Liquid (vanilla)	1.60	200 ml OP	✓ Fortini Multi Fibre
PEPTIDE-BASED ORAL FEED – Special Authority see SA1379 above – Hospital pharmacy [HP3]			
Powder	43.60	400 g OP	✓ Peptamen Junior

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
---	-----	--------------------------	-------------------------------------

Renal Products

►SA1101 Special Authority for Subsidy

Initial application only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years where the patient has acute or chronic kidney disease.

Renewal only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years for applications meeting the following criteria:

- Both:
- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
 - 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

RENAL ENTERAL FEED 1.8 KCAL/ML – Special Authority see [SA1101 above](#) – Hospital pharmacy [HP3]
Liquid.....6.08 500 ml OP ✓ **Nepro HP RTH**

RENAL ORAL FEED 1.8 KCAL/ML – Special Authority see [SA1101 above](#) – Hospital pharmacy [HP3]
Liquid.....2.67 220 ml OP ✓ **Nepro HP**
(strawberry)
✓ **Nepro HP (vanilla)**

RENAL ORAL FEED 2 KCAL/ML – Special Authority see [SA1101 above](#) – Hospital pharmacy [HP3]
Liquid.....2.88 237 ml OP
(3.31) NovaSource Renal
Liquid (apricot) 125 ml.....11.52 4 OP ✓ **Renilon 7.5**
Liquid (caramel) 125 ml.....11.52 4 OP ✓ **Renilon 7.5**

Specialised And Elemental Products

►SA1377 Special Authority for Subsidy

Initial application only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Any of the following:

- 1 malabsorption; or
- 2 short bowel syndrome; or
- 3 enterocutaneous fistulas; or
- 4 eosinophilic oesophagitis; or
- 5 inflammatory bowel disease; or
- 6 patients with multiple food allergies requiring enteral feeding.

Notes: Each of these products is highly specialised and would be prescribed only by an expert for a specific disorder. The alternative is hospitalisation.

Elemental 028 Extra is more expensive than other products listed in this section and should only be used where the alternatives have been tried first and/or are unsuitable.

Renewal only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

- Both:
- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
 - 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
ENTERAL/ORAL SEMI-ELEMENTAL FEED 1.5KCAL/ML – Special Authority see SA1377 on the previous page – Hospital pharmacy [HP3]			
Liquid	18.06	1,000 ml OP	✓ Vital
ORAL ELEMENTAL FEED 0.8KCAL/ML – Special Authority see SA1377 on the previous page – Hospital pharmacy [HP3]			
Liquid (grapefruit), 250 ml carton.....	171.00	18 OP	✓ Elemental 028 Extra
Liquid (pineapple & orange), 250 ml carton.....	171.00	18 OP	✓ Elemental 028 Extra
Liquid (summer fruits), 250 ml carton.....	171.00	18 OP	✓ Elemental 028 Extra
ORAL ELEMENTAL FEED 1KCAL/ML – Special Authority see SA1377 on the previous page – Hospital pharmacy [HP3]			
Powder (unflavoured)	4.50	80 g OP	✓ Vivonex TEN
SEMI-ELEMENTAL ENTERAL FEED 1KCAL/ML – Special Authority see SA1377 on the previous page – Hospital pharmacy [HP3]			
Liquid	12.04	1,000 ml OP	✓ Peptisorb

Paediatric Products For Children With Low Energy Requirements

►SA1196 Special Authority for Subsidy

Initial application only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Both:

- 1 Child aged one to eight years; and
- 2 The child has a low energy requirement but normal protein and micronutrient requirements.

Renewal only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

PAEDIATRIC ENTERAL FEED WITH FIBRE 0.76 KCAL/ML – Special Authority see [SA1196 above](#) – Hospital pharmacy [HP3]

Liquid	4.00	500 ml OP	✓ Nutrini Low Energy Multi Fibre
--------------	------	-----------	---

Standard Supplements

►SA1554 Special Authority for Subsidy

Initial application — (Children - indications other than exclusive enteral nutrition for Crohn's disease) only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

All of the following:

- 1 The patient is under 18 years of age; and
- 2 Any of the following:
 - 2.1 The patient has a condition causing malabsorption; or
 - 2.2 The patient has failure to thrive; or
 - 2.3 The patient has increased nutritional requirements; and
- 3 Nutrition goal has been set (eg reach a specific weight or BMI).

Renewal — (Children - indications other than exclusive enteral nutrition for Crohn's disease) only from a dietitian, relevant

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:
All of the following:

- 1 The patient is under 18 years of age; and
- 2 The treatment remains appropriate and the patient is benefiting from treatment; and
- 3 A nutrition goal has been set (eg reach a specific weight or BMI).

Initial application — (Children - exclusive enteral nutrition for Crohn's disease) only from a gastroenterologist or dietitian on the recommendation of a gastroenterologist. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 The patient is under 18 years of age; and
- 2 It is to be used as exclusive enteral nutrition for the treatment of Crohn's disease; and
- 3 Dietitians must include the name of the gastroenterologist recommending treatment and the date the gastroenterologist was contacted.

Renewal — (Children - exclusive enteral nutrition for Crohn's disease) only from a gastroenterologist, dietitian on the recommendation of a gastroenterologist or vocationally registered general practitioner on the recommendation of a gastroenterologist. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 The patient is under 18 years of age; and
- 2 It is to be used as exclusive enteral nutrition for the treatment of Crohn's disease; and
- 3 General Practitioners and dietitians must include the name of the gastroenterologist recommending treatment and the date the gastroenterologist was contacted.

Initial application — (Adults) only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 Any of the following:
Patient is Malnourished
 - 1.1 Patient has a body mass index (BMI) of less than 18.5 kg/m²; or
 - 1.2 Patient has unintentional weight loss greater than 10% within the last 3-6 months; or
 - 1.3 Patient has a BMI of less than 20 kg/m² and unintentional weight loss greater than 5% within the last 3-6 months; and
- 2 Any of the following:
Patient has not responded to first-line dietary measures over a 4 week period by:
 - 2.1 Increasing their food intake frequency (eg snacks between meals); or
 - 2.2 Using high-energy foods (e.g. milkshakes, full fat milk, butter, cream, cheese, sugar etc); or
 - 2.3 Using over the counter supplements (e.g. Complan); and
- 3 A nutrition goal has been set (e.g. to reach a specific weight or BMI).

Renewal — (Adults) only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 A nutrition goal has been set (eg reach a specific weight or BMI); and
- 2 Any of the following:
Patient is Malnourished
 - 2.1 Patient has a body mass index (BMI) of less than 18.5 kg/m²; or
 - 2.2 Patient has unintentional weight loss greater than 10% within the last 3-6 months; or
 - 2.3 Patient has a BMI of less than 20 kg/m² and unintentional weight loss greater than 5% within the last 3-6 months.

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

continued...

Initial application — (Short-term medical condition) only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Any of the following:

- 1 Is being fed via a nasogastric tube or a nasogastric tube is to be inserted for feeding; or
- 2 Malignancy and is considered likely to develop malnutrition as a result; or
- 3 Is undergoing a bone marrow transplant; or
- 4 Tempomandibular surgery or glossectomy; or
- 5 Both:
 - 5.1 Pregnant; and
 - 5.2 Any of the following:
 - 5.2.1 Patient is in early pregnancy (< 13 weeks) and has severe clinical hyperemesis gravidarum requiring admission to hospital and is unlikely to meet her nutritional requirements due to continuing hyperemesis gravidarum; or
 - 5.2.2 Patient has clinical hyperemesis gravidarum continuing past 13 weeks and either there is concern that the patient is unlikely to meet the Institute of Medicine's (1990) recommended weight gain guidelines for pregnancy or the patient's weight has not increased past her booking/pre-pregnancy weight; or
 - 5.2.3 Patient is having multiple births and is under the care of an obstetric team who consider the nutritional needs of the patient are not being met.

Renewal — (Short-term medical condition) only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner.

Approvals valid for 1 year for applications meeting the following criteria:

Any of the following:

- 1 Is being fed via a nasogastric tube; or
- 2 Malignancy and is considered likely to develop malnutrition as a result; or
- 3 Has undergone a bone marrow transplant; or
- 4 Tempomandibular surgery or glossectomy; or
- 5 Both:
 - 5.1 Pregnant; and
 - 5.2 Any of the following:
 - 5.2.1 Patient is in early pregnancy (< 13 weeks) and has severe clinical hyperemesis gravidarum requiring admission to hospital and is unlikely to meet her nutritional requirements due to continuing hyperemesis gravidarum; or
 - 5.2.2 Patient has clinical hyperemesis gravidarum continuing past 13 weeks and either there is concern that the patient is unlikely to meet the Institute of Medicine's (1990) recommended weight gain guidelines for pregnancy or the patient's weight has not increased past her booking/pre-pregnancy weight; or
 - 5.2.3 Patient is having multiple births and is under the care of an obstetric team who consider the nutritional needs of the patient are not being met.

Initial application — (Long-term medical condition) only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Any of the following:

- 1 Is being fed via a tube or a tube is to be inserted for the purpose of feeding (not nasogastric tube - refer to specific medical condition criteria); or
- 2 Cystic Fibrosis; or
- 3 Liver disease; or
- 4 Chronic Renal failure; or
- 5 Inflammatory bowel disease; or
- 6 Chronic obstructive pulmonary disease with hypercapnia; or
- 7 Short bowel syndrome; or

continued...

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

- 8 Bowel fistula; or
- 9 Severe chronic neurological conditions; or
- 10 Epidermolysis bullosa; or
- 11 AIDS (CD4 count < 200 cells/mm³); or
- 12 Chronic pancreatitis.

Renewal — (Chronic disease OR tube feeding for patients who have previously been funded under Special Authority forms SA0702 or SA0583) only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Any of the following:

- 1 Is being fed via a tube or a tube is to be inserted for the purpose of feeding (not nasogastric tube - refer to specific medical condition criteria); or
- 2 Cystic Fibrosis; or
- 3 Liver disease; or
- 4 Chronic Renal failure; or
- 5 Inflammatory bowel disease; or
- 6 Chronic obstructive pulmonary disease with hypercapnia; or
- 7 Short bowel syndrome; or
- 8 Bowel fistula; or
- 9 Severe chronic neurological conditions.

ENTERAL FEED 1.5KCAL/ML – Special Authority see [SA1554 on page 225](#) – Hospital pharmacy [HP3]

Liquid.....	7.00	1,000 ml OP	✓ Nutrison Energy
-------------	------	-------------	--------------------------

ENTERAL FEED 1KCAL/ML – Special Authority see [SA1554 on page 225](#) – Hospital pharmacy [HP3]

Liquid.....	1.24	250 ml OP	✓ Isosource Standard
	5.29	1,000 ml OP	✓ Nutrison Standard RTH
			✓ Osmolite RTH

ENTERAL FEED WITH FIBRE 0.83 KCAL/ML – Special Authority see [SA1554 on page 225](#) – Hospital pharmacy [HP3]

Liquid.....	5.29	1,000 ml OP	✓ Nutrison 800 Complete Multi Fibre
-------------	------	-------------	--

ENTERAL FEED WITH FIBRE 1 KCAL/ML – Special Authority see [SA1554 on page 225](#) – Hospital pharmacy [HP3]

Liquid.....	5.29	1,000 ml OP	✓ Jevity RTH
			✓ Nutrison Multi Fibre

ENTERAL FEED WITH FIBRE 1.5KCAL/ML – Special Authority see [SA1554 on page 225](#) – Hospital pharmacy [HP3]

Liquid.....	1.75	250 ml OP	✓ Ensure Plus HN
	7.00	1,000 ml OP	✓ Ensure Plus RTH
			✓ Jevity HiCal RTH
			✓ Nutrison Energy Multi Fibre

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
ORAL FEED (POWDER) – Special Authority see SA1554 on page 225 – Hospital pharmacy [HP3]			
Note: Higher subsidy for Sustagen Hospital Formula will only be reimbursed for patients with both a valid Special Authority number and an appropriately endorsed prescription.			
Powder (chocolate) – Higher subsidy of up to \$26.00 per 850 g			
with Endorsement.....	26.00	850 g OP	✓ Ensure
	9.54	840 g OP	
	(26.00)		Sustagen Hospital Formula Active
Additional subsidy by endorsement is available for patients with fat malabsorption, fat intolerance or chyle leak. The prescription must be endorsed accordingly.			
Powder (vanilla) – Higher subsidy of up to \$26.00 per 850 g			
with Endorsement.....	8.54	857 g OP	✓ Fortisip
	26.00	850 g OP	✓ Ensure
	9.54	840 g OP	
	(26.00)		Sustagen Hospital Formula Active
Additional subsidy by endorsement is available for patients with fat malabsorption, fat intolerance or chyle leak. The prescription must be endorsed accordingly.			
ORAL FEED 1.5KCAL/ML – Special Authority see SA1554 on page 225 – Hospital pharmacy [HP3]			
Additional subsidy by endorsement is available for patients being bolus fed through a feeding tube, who have severe epidermolysis bullosa, or as exclusive enteral nutrition in children under the age of 18 years for the treatment of Crohn's disease. The prescription must be endorsed accordingly.			
Liquid (banana) – Higher subsidy of \$1.26 per 200 ml with			
Endorsement.....	0.72	200 ml OP	
	(1.26)		Ensure Plus
	(1.26)		Fortisip
Liquid (chocolate) – Higher subsidy of \$1.26 per 200 ml with			
Endorsement.....	0.72	200 ml OP	
	(1.26)		Ensure Plus
	(1.26)		Fortisip
Liquid (fruit of the forest) – Higher subsidy of \$1.26 per 200 ml			
with Endorsement.....	0.72	200 ml OP	
	(1.26)		Ensure Plus
Liquid (strawberry) – Higher subsidy of \$1.26 per 200 ml with			
Endorsement.....	0.72	200 ml OP	
	(1.26)		Ensure Plus
	(1.26)		Fortisip
Liquid (vanilla) – Higher subsidy of up to \$1.33 per 237 ml with			
Endorsement.....	0.85	237 ml OP	
	(1.33)		Ensure Plus
	0.72	200 ml OP	
	(1.26)		Ensure Plus
	(1.26)		Fortisip

SPECIAL FOODS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
ORAL FEED WITH FIBRE 1.5 KCAL/ML – Special Authority see SA1554 on page 225 – Hospital pharmacy [HP3]				
Additional subsidy by endorsement is available for patients being bolus fed through a feeding tube, or who have severe epidermolysis bullosa. The prescription must be endorsed accordingly.				
Liquid (chocolate) – Higher subsidy of \$1.26 per 200 ml with				
Endorsement	0.72 (1.26)	200 ml OP		Fortisip Multi Fibre
Liquid (strawberry) – Higher subsidy of \$1.26 per 200 ml with				
Endorsement	0.72 (1.26)	200 ml OP		Fortisip Multi Fibre
Liquid (vanilla) – Higher subsidy of \$1.26 per 200 ml with				
Endorsement	0.72 (1.26)	200 ml OP		Fortisip Multi Fibre

High Calorie Products

►SA1195 Special Authority for Subsidy

Initial application — (Cystic fibrosis) only from a dietitian, relevant specialist or vocationally registered general practitioner.

Approvals valid for 3 years for applications meeting the following criteria:

All of the following:

- 1 Cystic fibrosis; and
- 2 other lower calorie products have been tried; and
- 3 patient has substantially increased metabolic requirements.

Initial application — (Indications other than cystic fibrosis) only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

All of the following:

- 1 Any of the following:
 - 1.1 any condition causing malabsorption; or
 - 1.2 faltering growth in an infant/child; or
 - 1.3 increased nutritional requirements; or
 - 1.4 fluid restricted; and
- 2 other lower calorie products have been tried; and
- 3 patient has substantially increased metabolic requirements or is fluid restricted.

Renewal — (Cystic fibrosis) only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

Renewal — (Indications other than cystic fibrosis) only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

ENTERAL FEED 2 KCAL/ML – Special Authority see [SA1195 above](#) – Hospital pharmacy [HP3]

Liquid	5.50	500 ml OP	✓ Nutrison Concentrated
	11.00	1,000 ml OP	✓ Two Cal HN RTH

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
ORAL FEED 2 KCAL/ML – Special Authority see SA1195 on the previous page – Hospital pharmacy [HP3]			
Additional subsidy by endorsement is available for patients being bolus fed through a feeding tube, or who have severe epidermolysis bullosa. The prescription must be endorsed accordingly.			
Liquid (vanilla) – Higher subsidy of \$1.90 per 200 ml with			
Endorsement.....	0.96 (1.90)	200 ml OP	Two Cal HN

Food Thickeners

►SA1106 Special Authority for Subsidy

Initial application only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year where the patient has motor neurone disease with swallowing disorder.

Renewal only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

FOOD THICKENER – Special Authority see [SA1106 above](#) – Hospital pharmacy [HP3]

Powder	6.53	300 g OP	✓ Nutilis
	7.25	380 g OP	✓ Feed Thickener Karicare Aptamil

Gluten Free Foods

The funding of gluten free foods is no longer being actively managed by PHARMAC from 1 April 2011. This means that we are no longer considering the listing of new products, or making subsidy, or other changes to the existing listings. As a result we anticipate that the range of funded items will reduce over time. Management of Coeliac disease with a gluten free diet is necessary for good outcomes. A range of gluten free options are available through retail outlets.

►SA1729 Special Authority for Subsidy

Initial application — (all patients) only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Either:

- 1 Gluten enteropathy has been diagnosed by biopsy; or
- 2 Patient suffers from dermatitis herpetiformis.

Initial application — (paediatric patients diagnosed by ESPGHAN criteria) only from a paediatric gastroenterologist. Approvals valid without further renewal unless notified where the paediatric patient fulfils ESPGHAN criteria for biopsy free diagnosis of coeliac disease.

GLUTEN FREE BAKING MIX – Special Authority see [SA1729 above](#) – Hospital pharmacy [HP3]

Powder	2.81	1,000 g OP	
	(5.15)		Healthies Simple Baking Mix

GLUTEN FREE BREAD MIX – Special Authority see [SA1729 above](#) – Hospital pharmacy [HP3]

Powder	3.93	1,000 g OP	
	(7.32)		NZB Low Gluten Bread Mix
	3.51		
	(10.87)		Horleys Bread Mix

SPECIAL FOODS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
GLUTEN FREE FLOUR – Special Authority see SA1729 on the previous page – Hospital pharmacy [HP3]				
Powder	5.62	2,000 g OP		
	(18.10)			Horleys Flour
GLUTEN FREE PASTA – Special Authority see SA1729 on the previous page – Hospital pharmacy [HP3]				
Buckwheat Spirals	2.00	250 g OP		
	(3.11)			Orgran
Corn and Vegetable Shells	2.00	250 g OP		
	(2.92)			Orgran
Corn and Vegetable Spirals	2.00	250 g OP		
	(2.92)			Orgran
Rice and Corn Lasagne Sheets	1.60	200 g OP		
	(3.82)			Orgran
Rice and Corn Macaroni	2.00	250 g OP		
	(2.92)			Orgran
Rice and Corn Penne	2.00	250 g OP		
	(2.92)			Orgran
Rice and Maize Pasta Spirals	2.00	250 g OP		
	(2.92)			Orgran
Rice and Millet Spirals	2.00	250 g OP		
	(3.11)			Orgran
Rice and corn spaghetti noodles	2.00	375 g OP		
	(2.92)			Orgran
Vegetable and Rice Spirals	2.00	250 g OP		
	(2.92)			Orgran
Italian long style spaghetti	2.00	220 g OP		
	(3.11)			Orgran

Foods And Supplements For Inborn Errors Of Metabolism

► [SA1108](#) Special Authority for Subsidy

Initial application only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Any of the following:

- 1 Dietary management of homocystinuria; or
- 2 Dietary management of maple syrup urine disease; or
- 3 Dietary management of phenylketonuria (PKU); or
- 4 For use as a supplement to the Ketogenic diet in patients diagnosed with epilepsy.

Supplements For Homocystinuria

AMINOACID FORMULA WITHOUT METHIONINE – Special Authority see [SA1108 above](#) – Hospital pharmacy [HP3]
 Powder461.94 500 g OP ✓ **XMET Maxamum**

Supplements For MSUD

AMINOACID FORMULA WITHOUT VALINE, LEUCINE AND ISOLEUCINE – Special Authority see [SA1108 above](#) – Hospital pharmacy [HP3]
 Powder437.22 500 g OP ✓ **MSUD Maxamum**

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
Supplements For PKU			
AMINOACID FORMULA WITHOUT PHENYLALANINE – Special Authority see SA1108 on the previous page – Hospital pharmacy [HP3]			
Tabs.....	99.00	75 OP	✓ Phlexy 10
Powder (unflavoured) 27.8 g sachets.....	936.00	30	✓ PKU Lophlex Powder
Powder (unflavoured) 36 g sachets.....	393.00	30	✓ PKU Anamix Junior
Infant formula.....	174.72	400 g OP	✓ PKU Anamix Infant
Powder (orange).....	221.00	500 g OP	✓ XP Maxamaid
	320.00		✓ XP Maxamum
Powder (unflavoured)	221.00	500 g OP	✓ XP Maxamaid
	320.00		✓ XP Maxamum
Liquid (berry)	13.10	125 ml OP	✓ PKU Anamix Junior LQ
Liquid (orange)	13.10	125 ml OP	✓ PKU Anamix Junior LQ
Liquid (unflavoured).....	13.10	125 ml OP	✓ PKU Anamix Junior LQ
Liquid (forest berries), 250 ml carton.....	540.00	18 OP	✓ Easiphen Liquid
Liquid (juicy tropical) 125 ml.....	936.00	30 OP	✓ PKU Lophlex LQ 20
Oral semi-solid (berries) 109 g.....	1,123.20	36 OP	✓ PKU Lophlex Sensation 20
Liquid (juicy berries) 62.5 ml.....	939.00	60 OP	✓ PKU Lophlex LQ 10
Liquid (juicy citrus) 62.5 ml.....	939.00	60 OP	✓ PKU Lophlex LQ 10
Liquid (juicy orange) 62.5 ml	939.00	60 OP	✓ PKU Lophlex LQ 10
Liquid (juicy berries) 125 ml.....	936.00	30 OP	✓ PKU Lophlex LQ 20
Liquid (juicy orange) 125 ml	936.00	30 OP	✓ PKU Lophlex LQ 20
<i>(XP Maxamaid Powder (orange) to be delisted 1 April 2019)</i>			
<i>(XP Maxamaid Powder (unflavoured) to be delisted 1 April 2019)</i>			

Foods

LOW PROTEIN BAKING MIX – Special Authority see SA1108 on the previous page – Hospital pharmacy [HP3]			
Powder	8.22	500 g OP	✓ Loprofin Mix
LOW PROTEIN PASTA – Special Authority see SA1108 on the previous page – Hospital pharmacy [HP3]			
Animal shapes	11.91	500 g OP	✓ Loprofin
Lasagne.....	5.95	250 g OP	✓ Loprofin
Low protein rice pasta	11.91	500 g OP	✓ Loprofin
Macaroni.....	5.95	250 g OP	✓ Loprofin
Penne	11.91	500 g OP	✓ Loprofin
Spaghetti	11.91	500 g OP	✓ Loprofin
Spirals.....	11.91	500 g OP	✓ Loprofin

Infant Formulae

For Williams Syndrome

►SA1110 Special Authority for Subsidy

Initial application only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year where the patient is an infant suffering from Williams Syndrome and associated hypercalcaemia.

Renewal only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

- Both:
- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
 - 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

LOW CALCIUM INFANT FORMULA – Special Authority see [SA1110 above](#) – Hospital pharmacy [HP3]

Powder	44.40	400 g OP	✓ Locasol
--------------	-------	----------	-----------

Gastrointestinal and Other Malabsorptive Problems

AMINO ACID FORMULA – Special Authority see [SA1219 below](#) – Hospital pharmacy [HP3]

Powder	43.60	400 g OP	✓ Alfamino Junior
	53.00		✓ Neocate LCP
Powder (unflavoured)	53.00	400 g OP	✓ Elecare
			✓ Elecare LCP
			✓ Neocate Gold
			✓ Neocate Junior Unflavoured
			✓ Neocate SYNEO
Powder (vanilla)	53.00	400 g OP	✓ Elecare
			✓ Neocate Junior Vanilla

(Neocate LCP Powder to be delisted 1 May 2019)

►SA1219 Special Authority for Subsidy

Initial application only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Any of the following:

- 1 Extensively hydrolysed formula has been reasonably trialled and is inappropriate due to documented severe intolerance or allergy or malabsorption; or
- 2 History of anaphylaxis to cows milk protein formula or dairy products; or
- 3 Eosinophilic oesophagitis.

Note: A reasonable trial is defined as a 2-4 week trial.

Renewal only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 An assessment as to whether the infant can be transitioned to a cows milk protein, soy, or extensively hydrolysed infant formula has been undertaken; and
- 2 The outcome of the assessment is that the infant continues to require an amino acid infant formula; and
- 3 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
EXTENSIVELY HYDROLYSED FORMULA – Special Authority see SA1557 below – Hospital pharmacy [HP3]			
Powder	15.21	450 g OP	✓ Aptamil Gold+ Pepti Junior

► **SA1557** Special Authority for Subsidy

Initial application only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Any of the following:

- 1 Both:
 - 1.1 Cows milk formula is inappropriate due to severe intolerance or allergy to its protein content; and
 - 1.2 Either:
 - 1.2.1 Soy milk formula has been reasonably trialled without resolution of symptoms; or
 - 1.2.2 Soy milk formula is considered clinically inappropriate or contraindicated; or
- 2 Severe malabsorption; or
- 3 Short bowel syndrome; or
- 4 Intractable diarrhoea; or
- 5 Biliary atresia; or
- 6 Cholestatic liver diseases causing malabsorption; or
- 7 Cystic fibrosis; or
- 8 Proven fat malabsorption; or
- 9 Severe intestinal motility disorders causing significant malabsorption; or
- 10 Intestinal failure; or
- 11 All of the following:
 - 11.1 For step down from Amino Acid Formula; and
 - 11.2 The infant is currently receiving funded amino acid formula; and
 - 11.3 The infant is to be trialled on, or transitioned to, an extensively hydrolysed formula; and
 - 11.4 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and the date contacted.

Note: A reasonable trial is defined as a 2-4 week trial, or signs of an immediate IgE mediated allergic reaction.

Renewal only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 An assessment as to whether the infant can be transitioned to a cows milk protein or soy infant formula has been undertaken; and
- 2 The outcome of the assessment is that the infant continues to require an extensively hydrolysed infant formula; and
- 3 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and the date contacted.

Fluid Restricted

PAEDIATRIC ORAL/ENTERAL FEED 1 KCAL/ML – Special Authority see [SA1698 below](#) – Hospital pharmacy [HP3]

Liquid 2.35 125 ml OP ✓ Infatrini

► **SA1698** Special Authority for Subsidy

Initial application only from a paediatrician, dietitian or general practitioner on the recommendation of a paediatrician or dietitian. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient is fluid restricted or volume intolerant and has been diagnosed with faltering growth; and
- 2 Patient is under the care of a paediatrician or dietitian who has recommended treatment with a high energy infant formula;

continued...

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
--	---	-----	--------------------------	-------------------------------------

continued...

and

- 3 Patient is under 18 months of age or weighs less than 8 kg.

Note: 'Volume intolerant' patients are those who are unable to tolerate an adequate volume of infant formula to achieve expected growth rate. These patients should have first trialled appropriate clinical alternative treatments, such as concentrating, fortifying and adjusting the frequency of feeding.

Renewal only from a paediatrician, dietitian or general practitioner on the recommendation of a paediatrician or dietitian.

Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient continues to be fluid restricted or volume intolerant and has faltering growth; and
- 2 Patient is under the care of a hospital paediatrician or dietitian who has recommended treatment with a high energy infant formula; and
- 3 Patient is under 18 months of age or weighs less than 8 kg.

Note: 'Volume intolerant' patients are those who are unable to tolerate an adequate volume of infant formula to achieve expected growth rate. These patients should have first trialled appropriate clinical alternative treatments, such as concentrating, fortifying and adjusting the frequency of feeding.

Ketogenic Diet

►SA1197 Special Authority for Subsidy

Initial application only from a metabolic physician or paediatric neurologist. Approvals valid for 3 months where the patient has intractable epilepsy, pyruvate dehydrogenase deficiency or glucose transported type-1 deficiency and other conditions requiring a ketogenic diet.

Renewal only from a metabolic physician or paediatric neurologist. Approvals valid for 2 years where the patient is on a ketogenic diet and the patient is benefiting from the diet.

HIGH FAT LOW CARBOHYDRATE FORMULA – Special Authority see [SA1197 above](#) – Retail pharmacy

Powder (unflavoured)	35.50	300 g OP	✓ KetoCal 4:1
			✓ Ketocal 3:1
Powder (vanilla).....	35.50	300 g OP	✓ KetoCal 4:1

SECTION I: NATIONAL IMMUNISATION SCHEDULE

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
Vaccinations			
ADULT DIPHTHERIA AND TETANUS VACCINE – [Xpharm]			
Inj 2 IU diphtheria toxoid with 20 IU tetanus toxoid in 0.5 ml.....	0.00	5	✓ ADT Booster
Any of the following:			
1) For vaccination of patients aged 45 and 65 years old; or			
2) For vaccination of previously unimmunised or partially immunised patients; or			
3) For revaccination following immunosuppression; or			
4) For boosting of patients with tetanus-prone wounds; or			
5) For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician.			
Note: Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes.			
BACILLUS CALMETTE-GUERIN VACCINE – [Xpharm]			
For infants at increased risk of tuberculosis. Increased risk is defined as:			
1) living in a house or family with a person with current or past history of TB; or			
2) having one or more household members or carers who within the last 5 years lived in a country with a rate of TB > or equal to 40 per 100,000 for 6 months or longer; or			
3) during their first 5 years will be living 3 months or longer in a country with a rate of TB > or equal to 40 per 100,000			
Note a list of countries with high rates of TB are available at www.health.govt.nz/tuberculosis (search for downloads) or www.bcgatlas.org/index.php .			
Inj Mycobacterium bovis BCG (Bacillus Calmette-Guerin), Danish strain 1331, live attenuated, vial with diluent.....	0.00	10	✓ BCG Vaccine
DIPHTHERIA, TETANUS AND PERTUSSIS VACCINE – [Xpharm]			
Funded for any of the following criteria:			
1) A single vaccine for pregnant woman between gestational weeks 28 and 38; or			
2) A course of up to four vaccines is funded for children from age 7 up to the age of 18 years inclusive to complete full primary immunisation; or			
3) An additional four doses (as appropriate) are funded for (re-)immunisation for patients post haematopoietic stem cell transplantation or chemotherapy; pre or post splenectomy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens.			
Notes: Tdap is not registered for patients aged less than 10 years. Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes.			
Inj 2 IU diphtheria toxoid with 20 IU tetanus toxoid, 8 mcg pertussis toxoid, 8 mcg pertussis filamentous haemagglutinin and 2.5 mcg pertactin in 0.5 ml syringe	0.00	10 1	✓ Boostrix ✓ Boostrix
DIPHTHERIA, TETANUS, PERTUSSIS AND POLIO VACCINE – [Xpharm]			
Funded for any of the following:			
1) A single dose for children up to the age of 7 who have completed primary immunisation; or			
2) A course of four vaccines is funded for catch up programmes for children (to the age of 10 years) to complete full primary immunisation; or			
3) An additional four doses (as appropriate) are funded for (re-)immunisation for patients post HSCT, or chemotherapy; pre- or post splenectomy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens; or			
4) Five doses will be funded for children requiring solid organ transplantation.			
Note: Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes.			
Inj 30 IU diphtheria toxoid with 40 IU tetanus toxoid, 25 mcg pertussis toxoid, 25 mcg pertussis filamentous haemagglutinin, 8 mcg pertactin and 80 D-antigen units poliomyelitis virus in 0.5ml syringe	0.00	10	✓ Infranrix IPV

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

*Three months or six months, as applicable, dispensed all-at-once

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
DIPHTHERIA, TETANUS, PERTUSSIS, POLIO, HEPATITIS B AND HAEMOPHILUS INFLUENZAE TYPE B VACCINE – [Xpharm]				
Funded for patients meeting any of the following criteria:				
1) Up to four doses for children up to and under the age of 10 for primary immunisation; or				
2) An additional four doses (as appropriate) are funded for (re-)immunisation for children up to and under the age of 10 who are patients post haematopoietic stem cell transplantation, or chemotherapy; pre or post splenectomy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens; or				
3) Up to five doses for children up to and under the age of 10 receiving solid organ transplantation.				
Note: A course of up-to four vaccines is funded for catch up programmes for children (up to and under the age of 10 years) to complete full primary immunisation. Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes.				
Inj 30IU diphtheriatoxoid with 40IU tetanustoxoid, 25mcg pertussistoxoid, 25mcg pertussisfilamentoushaemagglutinin, 8 mcgpertactin, 80 D-AgUpoliiovirus, 10mcghepatitisBsurfaceantigen in 0.5ml syringe	0.00	10	✓	<u>Infanrix-hexa</u>
HAEMOPHILUS INFLUENZAE TYPE B VACCINE – [Xpharm]				
One dose for patients meeting any of the following:				
1) For primary vaccination in children; or				
2) An additional dose (as appropriate) is funded for (re-)immunisation for patients post haematopoietic stem cell transplantation, or chemotherapy; functional asplenic; pre or post splenectomy; pre- or post solid organ transplant, pre- or post cochlear implants, renal dialysis and other severely immunosuppressive regimens; or				
3) For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician.				
Haemophilus Influenzae type B polysaccharide 10 mcg conjugated to tetanus toxoid as carrier protein 20-40 mcg; prefilled syringe plus vial 0.5 ml.....	0.00	1	✓	<u>Hiberix</u>
HEPATITIS A VACCINE – [Xpharm]				
Funded for patients meeting any of the following criteria:				
1) Two vaccinations for use in transplant patients; or				
2) Two vaccinations for use in children with chronic liver disease; or				
3) One dose of vaccine for close contacts of known hepatitis A cases.				
Inj 1440 ELISA units in 1 ml syringe.....	0.00	1	✓	<u>Havrix</u>
Inj 720 ELISA units in 0.5 ml syringe.....	0.00	1	✓	<u>Havrix Junior</u>

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
HEPATITIS B RECOMBINANT VACCINE – [Xpharm]			
Inj 5 mcg per 0.5 ml vial.....	0.00	1	✓ HBvaxPRO
Funded for patients meeting any of the following criteria:			
<ol style="list-style-type: none"> 1) for household or sexual contacts of known acute hepatitis B patients or hepatitis B carriers; or 2) for children born to mothers who are hepatitis B surface antigen (HBsAg) positive; or 3) for children up to and under the age of 18 years inclusive who are considered not to have achieved a positive serology and require additional vaccination or require a primary course of vaccination; or 4) for HIV positive patients; or 5) for hepatitis C positive patients; or 6) for patients following non-consensual sexual intercourse; or 7) for patients following immunosuppression; or 8) for solid organ transplant patients; or 9) for post-haematopoietic stem cell transplant (HSCT) patients; or 10) following needle stick injury. 			
Inj 10 mcg per 1 ml vial.....	0.00	1	✓ HBvaxPRO
Funded for patients meeting any of the following criteria:			
<ol style="list-style-type: none"> 1) for household or sexual contacts of known acute hepatitis B patients or hepatitis B carriers; or 2) for children born to mothers who are hepatitis B surface antigen (HBsAg) positive; or 3) for children up to and under the age of 18 years inclusive who are considered not to have achieved a positive serology and require additional vaccination or require a primary course of vaccination; or 4) for HIV positive patients; or 5) for hepatitis C positive patients; or 6) for patients following non-consensual sexual intercourse; or 7) for patients following immunosuppression; or 8) for solid organ transplant patients; or 9) for post-haematopoietic stem cell transplant (HSCT) patients; or 10) following needle stick injury. 			
Inj 20 mcg per 1 ml prefilled syringe.....	0.00	1	✓ Engerix-B
Funded for patients meeting any of the following criteria:			
<ol style="list-style-type: none"> 1) for household or sexual contacts of known acute hepatitis B patients or hepatitis B carriers; or 2) for children born to mothers who are hepatitis B surface antigen (HBsAg) positive; or 3) for children up to and under the age of 18 years inclusive who are considered not to have achieved a positive serology and require additional vaccination or require a primary course of vaccination; or 4) for HIV positive patients; or 5) for hepatitis C positive patients; or 6) for patients following non-consensual sexual intercourse; or 7) for patients following immunosuppression; or 8) for solid organ transplant patients; or 9) for post-haematopoietic stem cell transplant (HSCT) patients; or 10) following needle stick injury. 			
Inj 40 mcg per 1 ml vial.....	0.00	1	✓ HBvaxPRO
Funded for any of the following criteria:			
<ol style="list-style-type: none"> 1) for dialysis patients; or 2) for liver or kidney transplant patient. 			

NATIONAL IMMUNISATION SCHEDULE

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
HUMAN PAPILLOMAVIRUS (6, 11, 16, 18, 31, 33, 45, 52 AND 58) VACCINE [HPV] – [Xpharm]			
Any of the following:			
1) Maximum of two doses for children aged 14 years and under; or			
2) Maximum of three doses for patients meeting any of the following criteria:			
1) People aged 15 to 26 years inclusive; or			
2) Either:			
People aged 9 to 26 years inclusive			
1) Confirmed HIV infection; or			
2) Transplant (including stem cell) patients: or			
3) Maximum of four doses for people aged 9 to 26 years inclusive post chemotherapy			
Inj 270 mcg in 0.5 ml syringe.....	0.00	10	✓ Gardasil 9

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
INFLUENZA VACCINE			
Inj 45 mcg in 0.5 ml syringe (trivalent vaccine).....	90.00	10	✓ Influvac
<ul style="list-style-type: none"> a) Only on a prescription b) No patient co-payment payable c) <ul style="list-style-type: none"> A) is available each year for patients who meet the following criteria, as set by PHARMAC, for use if a funded quadrivalent influenza vaccine is not available: <ul style="list-style-type: none"> a) all people 65 years of age and over; or b) people under 65 years of age who: <ul style="list-style-type: none"> i) have any of the following cardiovascular diseases: <ul style="list-style-type: none"> a) ischaemic heart disease, or b) congestive heart failure, or c) rheumatic heart disease, or d) congenital heart disease, or e) cerebo-vascular disease; or ii) have either of the following chronic respiratory diseases: <ul style="list-style-type: none"> a) asthma, if on a regular preventative therapy, or b) other chronic respiratory disease with impaired lung function; or iii) have diabetes; or iv) have chronic renal disease; or v) have any cancer, excluding basal and squamous skin cancers if not invasive; or vi) have any of the following other conditions: <ul style="list-style-type: none"> a) autoimmune disease, or b) immune suppression or immune deficiency, or c) HIV, or d) transplant recipients, or e) neuromuscular and CNS diseases/disorders, or f) haemoglobinopathies, or g) on long term aspirin, or h) have a cochlear implant, or i) errors of metabolism at risk of major metabolic decompensation, or j) pre and post splenectomy, or k) down syndrome, or vii) are pregnant; or c) children aged four years and under who have been hospitalised for respiratory illness or have a history of significant respiratory illness; d) people under 18 years of age living in the Seddon/Ward and rural Eastern Marlborough region (within the Nelson Marlborough District Health Board) and Kaikoura and Hurunui areas (within the Canterbury District Health Board); e) People under 18 years of age who have been displaced from their homes in Edgecumbe and the surrounding region; 			
<p>Unless meeting the criteria set out above, the following conditions are excluded from funding:</p> <ul style="list-style-type: none"> a) asthma not requiring regular preventative therapy, b) hypertension and/or dyslipidaemia without evidence of end-organ disease. 			
<p>B) Contractors will be entitled to claim payment from the Funder for the supply of influenza vaccine to patients eligible under the above criteria pursuant to their contract with their DHB for subsidised immunisation, and they may only do so in respect of the influenza vaccine listed in the Pharmaceutical Schedule.</p>			
<p>C) Contractors may only claim for patient populations within the criteria that are covered by their contract, which may be a sub-set of the population described in paragraph A above.</p>			
Inj 60 mcg in 0.5 ml syringe (paediatric quadrivalent vaccine) – [Xpharm].....	9.00	1	✓ Fluarix Tetra

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<p>A) INFLUENZA VACCINE – child aged 6 months to 35 months is available each year for patients aged 6 months to 35 months who meet the following criteria, as set by PHARMAC:</p> <ul style="list-style-type: none"> i) have any of the following cardiovascular diseases <ul style="list-style-type: none"> a) ischaemic heart disease, or b) congestive heart failure, or c) rheumatic heart disease, or d) congenital heart disease, or e) cerebo-vascular disease; or ii) have either of the following chronic respiratory diseases: <ul style="list-style-type: none"> a) asthma, if on a regular preventative therapy, or b) other chronic respiratory disease with impaired lung function; or iii) have diabetes; or iv) have chronic renal disease; or v) have any cancer, excluding basal and squamous skin cancers if not invasive; or vi) have any of the following other conditions: <ul style="list-style-type: none"> a) autoimmune disease, or b) immune suppression or immune deficiency, or c) HIV, or d) transplant recipients, or e) neuromuscular and CNS diseases/disorders, or f) haemoglobinopathies, or g) on long term aspirin, or h) have a cochlear implant, or i) errors of metabolism at risk of major metabolic decompensation, or j) pre and post splenectomy, or k) down syndrome, or vii) have been hospitalised for respiratory illness or have a history of significant respiratory illness; viii) are living in the Seddon/Ward and rural Eastern Marlborough region (within the Nelson Marlborough District Health Board) and Kaikoura and Hurunui areas (within the Canterbury District Health Board); ix) have been displaced from their homes in Edgecumbe and the surrounding region; <p>Unless meeting the criteria set out above, the following conditions are excluded from funding:</p> <ul style="list-style-type: none"> a) asthma not requiring regular preventative therapy, b) hypertension and/or dyslipidaemia without evidence of end-organ disease. <p>B) Doctors are the only Contractors entitled to claim payment from the Funder for the supply of influenza vaccine inj 60 mcg in 0.5 ml syringe (paediatric quadrivalent vaccine) to patients eligible under the above criteria for subsidised immunisation and they may only do so in respect of the influenza vaccine listed in the Pharmaceutical Schedule.</p>				
Inj 60 mcg in 0.5 ml syringe (quadrivalent vaccine).....	90.00	10	✓	Influvac Tetra

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
---	------------------------------	-------------------------------------

- a) Only on a prescription
- b) No patient co-payment payable
- c)

A) INFLUENZA VACCINE – people 3 years and over

is available each year for patients aged 3 years and over who meet the following criteria, as set by PHARMAC:

- a) all people 65 years of age and over; or
- b) people under 65 years of age who:
 - i) have any of the following cardiovascular diseases:
 - a) ischaemic heart disease, or
 - b) congestive heart failure, or
 - c) rheumatic heart disease, or
 - d) congenital heart disease, or
 - e) cerebro-vascular disease; or
 - ii) have either of the following chronic respiratory diseases:
 - a) asthma, if on a regular preventative therapy, or
 - b) other chronic respiratory disease with impaired lung function; or
 - iii) have diabetes; or
 - iv) have chronic renal disease; or
 - v) have any cancer, excluding basal and squamous skin cancers if not invasive; or
 - vi) have any of the following other conditions:
 - a) autoimmune disease, or
 - b) immune suppression or immune deficiency, or
 - c) HIV, or
 - d) transplant recipients, or
 - e) neuromuscular and CNS diseases/disorders, or
 - f) haemoglobinopathies, or
 - g) are children on long term aspirin, or
 - h) have a cochlear implant, or
 - i) errors of metabolism at risk of major metabolic decompensation, or
 - j) pre and post splenectomy, or
 - k) down syndrome, or
 - vii) are pregnant; or
- c) children aged four years or less (but over three years) who have been hospitalised for respiratory illness or have a history of significant respiratory illness;
- d) people under 18 years of age living in the Seddon/Ward and rural Eastern Marlborough region (within the Nelson Marlborough District Health Board) and Kaikoura and Hurunui areas (within the Canterbury District Health Board);
- e) People under 18 years of age who have been displaced from their homes in Edgecumbe and the surrounding region;

Unless meeting the criteria set out above, the following conditions are excluded from funding:

- a) asthma not requiring regular preventative therapy,
 - b) hypertension and/or dyslipidaemia without evidence of end-organ disease.
- B) Contractors will be entitled to claim payment from the Funder for the supply of influenza vaccine to patients eligible under the above criteria pursuant to their contract with their DHB for subsidised immunisation, and they may only do so in respect of the influenza vaccine listed in the Pharmaceutical Schedule.
- C) Contractors may only claim for patient populations within the criteria that are covered by their contract, which may be a sub-set of the population described in paragraph A above.

NATIONAL IMMUNISATION SCHEDULE

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
MEASLES, MUMPS AND RUBELLA VACCINE – [Xpharm]				
A maximum of two doses for any patient meeting the following criteria:				
<ol style="list-style-type: none"> 1) For primary vaccination in children; or 2) For revaccination following immunosuppression; or 3) For any individual susceptible to measles, mumps or rubella; or 4) A maximum of three doses for children who have had their first dose prior to 12 months. 				
Note: Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes.				
Inj, measles virus 1,000 CCID50, mumps virus 5,012 CCID50, Rubella virus 1,000 CCID50; prefilled syringe/ampoule of diluent 0.5 ml	0.00	10	✓	Priorix
MENINGOCOCCAL (GROUPS A, C, Y AND W-135) CONJUGATE VACCINE – [Xpharm]				
Any of the following:				
<ol style="list-style-type: none"> 1) Up to three doses and a booster every five years for patients pre- and post splenectomy and for patients with functional or anatomic asplenia, HIV, complement deficiency (acquired or inherited), or pre or post solid organ transplant; or 2) One dose for close contacts of meningococcal cases; or 3) A maximum of two doses for bone marrow transplant patients; or 4) A maximum of two doses for patients following immunosuppression*. 				
Note: children under seven years of age require two doses 8 weeks apart, a booster dose three years after the primary series and then five yearly.				
*Immunosuppression due to steroid or other immunosuppressive therapy must be for a period of greater than 28 days.				
Inj 4 mcg of each meningococcal polysaccharide conjugated to a total of approximately 48 mcg of diphtheria toxoid carrier per 0.5 ml vial	0.00	1	✓	Menactra
MENINGOCOCCAL C CONJUGATE VACCINE – [Xpharm]				
Any of the following:				
<ol style="list-style-type: none"> 1) Up to three doses and a booster every five years for patients pre- and post splenectomy and for patients with functional or anatomic asplenia, HIV, complement deficiency (acquired or inherited), or pre or post solid organ transplant; or 2) One dose for close contacts of meningococcal cases; or 3) A maximum of two doses for bone marrow transplant patients; or 4) A maximum of two doses for patients following immunosuppression*. 				
Note: children under seven years of age require two doses 8 weeks apart, a booster dose three years after the primary series and then five yearly.				
*Immunosuppression due to steroid or other immunosuppressive therapy must be for a period of greater than 28 days.				
Inj 10 mcg in 0.5 ml syringe	0.00	1	✓	Neisvac-C
PNEUMOCOCCAL (PCV10) CONJUGATE VACCINE – [Xpharm]				
Either:				
<ol style="list-style-type: none"> 1) A primary course of four doses for previously unvaccinated individuals up to the age of 59 months inclusive; or 2) Up to three doses as appropriate to complete the primary course of immunisation for individuals under the age of 59 months who have received one to three doses of PCV13. 				
Note: please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes				
Inj 1 mcg of pneumococcal polysaccharide serotypes 1, 5, 6B, 7F, 9V, 14 and 23F; 3 mcg of pneumococcal polysaccharide serotypes 4, 18C and 19F in 0.5 ml prefilled syringe	0.00	10	✓	Synflorix

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
--	---	------------------------------	-------------------------------------

PNEUMOCOCCAL (PCV13) CONJUGATE VACCINE – [Xpharm]

Any of the following:

- 1) One dose is funded for high risk children (over the age of 17 months and under 18 years) who have previously received four doses of PCV10; or
- 2) Up to an additional four doses (as appropriate) are funded for high risk children aged under 5 years for (re-)immunisation of patients with any of the following:
 - a) on immunosuppressive therapy or radiation therapy, vaccinate when there is expected to be a sufficient immune response; or
 - b) with primary immune deficiencies; or
 - c) with HIV infection; or
 - d) with renal failure, or nephrotic syndrome; or
 - e) who are immune-suppressed following organ transplantation (including haematopoietic stem cell transplant); or
 - f) with cochlear implants or intracranial shunts; or
 - g) with cerebrospinal fluid leaks; or
 - h) receiving corticosteroid therapy for more than two weeks, and who are on an equivalent daily dosage of prednisone of 2 mg/kg per day or greater, or children who weigh more than 10 kg on a total daily dosage of 20 mg or greater; or
 - i) with chronic pulmonary disease (including asthma treated with high-dose corticosteroid therapy); or
 - j) pre term infants, born before 28 weeks gestation; or
 - k) with cardiac disease, with cyanosis or failure; or
 - l) with diabetes; or
 - m) with Down syndrome; or
 - n) who are pre-or post-splenectomy, or with functional asplenia; or
- 3) Up to an additional four doses (as appropriate) are funded for (re-)immunisation of patients 5 years and over with HIV, for patients pre or post haematopoietic stem cell transplantation, or chemotherapy; pre- or post splenectomy; functional asplenia, pre- or post- solid organ transplant, renal dialysis, complement deficiency (acquired or inherited), cochlear implants, or primary immunodeficiency; or
- 4) For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician.

Note: please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes

Inj 30.8 mcg of pneumococcal polysaccharide serotypes 1, 3, 4,

5, 6A, 6B, 7F, 9V, 14, 18C, 19A, 19F and 23F in 0.5ml

syringe.....	0.00	10	✓ Prevenar 13
		1	✓ Prevenar 13

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
PNEUMOCOCCAL (PPV23) POLYSACCHARIDE VACCINE – [Xpharm]				
Either:				
1) Up to three doses (as appropriate) for patients with HIV, for patients post haematopoietic stem cell transplant, or chemotherapy; pre- or post-splenectomy or with functional asplenia, pre- or post-solid organ transplant, renal dialysis, complement deficiency (acquired or inherited), cochlear implants, or primary immunodeficiency; or				
2) All of the following:				
a) Patient is a child under 18 years for (re-)immunisation; and				
b) Treatment is for a maximum of two doses; and				
c) Any of the following:				
i) on immunosuppressive therapy or radiation therapy, vaccinate when there is expected to be a sufficient immune response; or				
ii) with primary immune deficiencies; or				
iii) with HIV infection; or				
iv) with renal failure, or nephrotic syndrome; or				
v) who are immune-suppressed following organ transplantation (including haematopoietic stem cell transplant); or				
vi) with cochlear implants or intracranial shunts; or				
vii) with cerebrospinal fluid leaks; or				
viii) receiving corticosteroid therapy for more than two weeks, and who are on an equivalent daily dosage of prednisone of 2 mg/kg per day or greater, or children who weigh more than 10 kg on a total daily dosage of 20 mg or greater; or				
ix) with chronic pulmonary disease (including asthma treated with high-dose corticosteroid therapy); or				
x) pre term infants, born before 28 weeks gestation; or				
xi) with cardiac disease, with cyanosis or failure; or				
xii) with diabetes; or				
xiii) with Down syndrome; or				
xiv) who are pre-or post-splenectomy, or with functional asplenia.				
Inj 575 mcg in 0.5 ml prefilled syringe (25 mcg of each 23 pneumococcal serotype)	0.00	1	✓	<u>Pneumovax 23</u>
POLIOMYELITIS VACCINE – [Xpharm]				
Up to three doses for patients meeting either of the following:				
1) For partially vaccinated or previously unvaccinated individuals; or				
2) For revaccination following immunosuppression.				
Note: Please refer to the Immunisation Handbook for appropriate schedule for catch-up programmes.				
Inj 80D antigen units in 0.5 ml syringe.....	0.00	1	✓	<u>IPOL</u>
ROTAVIRUS ORAL VACCINE – [Xpharm]				
Maximum of two doses for patients meeting the following:				
1) first dose to be administered in infants aged under 14 weeks of age; and				
2) no vaccination being administered to children aged 24 weeks or over.				
Oral susp live attenuated human rotavirus 1,000,000 CCID50 per dose, prefilled oral applicator.....	0.00	10	✓	<u>Rotarix</u>

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
--	---	------------------------------	-------------------------------------

VARICELLA VACCINE [CHICKENPOX VACCINE] – [Xpharm]

Either:

- 1) Maximum of one dose for primary vaccination for either:
 - a) Any infant born on or after 1 April 2016; or
 - b) For previously unvaccinated children turning 11 years old on or after 1 July 2017, who have not previously had a varicella infection (chickenpox), or
- 2) Maximum of two doses for any of the following:
 - a) Any of the following for non-immune patients:
 - i) with chronic liver disease who may in future be candidates for transplantation; or
 - ii) with deteriorating renal function before transplantation; or
 - iii) prior to solid organ transplant; or
 - iv) prior to any elective immunosuppression*, or
 - v) for post exposure prophylaxis who are immune competent inpatients.; or
 - b) For patients at least 2 years after bone marrow transplantation, on advice of their specialist, or
 - c) For patients at least 6 months after completion of chemotherapy, on advice of their specialist, or
 - d) For HIV positive non immune to varicella with mild or moderate immunosuppression on advice of HIV specialist, or
 - e) For patients with inborn errors of metabolism at risk of major metabolic decompensation, with no clinical history of varicella, or
 - f) For household contacts of paediatric patients who are immunocompromised, or undergoing a procedure leading to immune compromise where the household contact has no clinical history of varicella, or
 - g) For household contacts of adult patients who have no clinical history of varicella and who are severely immunocompromised, or undergoing a procedure leading to immune compromise where the household contact has no clinical history of varicella.

* immunosuppression due to steroid or other immunosuppressive therapy must be for a treatment period of greater than 28 days

Inj 2000 PFU prefilled syringe plus vial	0.00	1	✓ Varilrix
		10	✓ Varilrix

VARICELLA ZOSTER VIRUS (OKA STRAIN) LIVE ATTENUATED VACCINE [SHINGLES VACCINE] – [Xpharm]

Funded for patients meeting either of the following criteria:

- 1) One dose for all people aged 65 years; or
- 2) One dose for all people aged between 66 and 80 years inclusive from 1 April 2018 and 31 March 2020.

Inj 19,400 PFU prefilled syringe plus vial	0.00	1	✓ Zostavax
		10	✓ Zostavax

Diagnostic Agents

TUBERCULIN PPD [MANTOUX] TEST – [Xpharm]

Inj 5 TU per 0.1 ml, 1 ml vial.....	0.00	1	✓ Tubersol
-------------------------------------	------	---	-------------------

- Symbols -

3TC.....	108
50X 3.0 Reservoir.....	25

- A -

A-Scabies	69
Abacavir sulphate	107
Abacavir sulphate with lamivudine	107
Abiraterone acetate	171
Acarbose	11
Accuretic 10.....	48
Accuretic 20.....	48
Acetazolamide.....	210
Acetic acid with 1, 2- propanediol diacetate and benzethonium	208
Acetic acid with hydroxyquinoline and ricinoleic acid.....	75
Acetylcysteine.....	213
Aci-Jel.....	75
Aciclovir	
Infection	103
Sensory.....	208
Acidex.....	6
Acipimox	54
Acitretin.....	69
Aclasta.....	117
Aclin.....	112
Actinomycin D.....	161
Actrapid	10
Actrapid Penfill.....	10
Acupan	124
Adalat 10	52
Adalat Oros.....	52
Adalimumab.....	180
Adapalene	61
Adefin	52
Adefin XL.....	52
Adefovir dipivoxil.....	102
Adenuric.....	120
ADR Cartridge 1.8	25
Adrenaline	56
ADT Booster.....	237
Adult diphtheria and tetanus vaccine	237
Advantan	64
Advate	40
Afinitor.....	198
Aflibercept.....	187
AFT Carbimazole.....	83
AFT SLS-free.....	66
AFT-Pyrazinamide.....	101
AFT-Pyrazinamide S29.....	101
Agents Affecting the	

Renin-Angiotensin System	47
Agents for Parkinsonism and Related Disorders	122
Agents Used in the Treatment of Poisonings.....	213
Agrylin.....	160
Alanase.....	206
Albendazole.....	90
Albey.....	200
Albustix.....	77
Aldurazyme.....	29
Alendronate sodium.....	114–115
Alendronate sodium with colecalfiferol.....	114
Alfacalcidol	34
Alfamino Junior.....	234
Alginic acid	6
Alglucosidase alfa.....	27
Alkeran	157
Allersoothe.....	201
Allmercap.....	159
Allopurinol.....	119
Alpha-Adrenoceptor Blockers.....	47
Alpha-Keri Lotion.....	66
Alphamox 125.....	93
Alphamox 250.....	93
Alu-Tab.....	6
Aluminium hydroxide	6
Amantadine hydrochloride.....	122
Ambrisentan	57
Amiloride hydrochloride.....	53
Amiloride hydrochloride with furosemide.....	54
Amiloride hydrochloride with hydrochlorothiazide	54
Aminophylline.....	206
Amiodarone hydrochloride.....	49
Amisulpride.....	135
Amitriptyline	127
Amlodipine.....	51
Amorolfine	62
Amoxicillin.....	93
Amoxicillin with clavulanic acid	93
Amphotericin B.....	33
Amsacrine.....	160
AmsaLyo.....	160
Amsidine.....	160
Amzoate	30
Anaesthetics	123
Anagrelide hydrochloride.....	160
Analgesics	124
Anastrozole.....	173
Andriol Testocaps.....	81
Androderm.....	80

Animas Battery Cap.....	19
Animas Cartridge	25
Anoro Ellipta	204
Antabuse	152
Antacids and Antiflatulents	6
Anten.....	128
Anthelmintics	90
Antiacne Preparations	61
Antiallergy Preparations	200
Antianaemics.....	37
Antiandrogen Oral Contraceptives.....	74
Antiarrhythmics.....	49
Antibacterials.....	90
Antibacterials Topical	62
Anticholinergic Agents.....	203
Anticholinesterases	112
Antidepressants.....	127
Antidiarrhoeals.....	6
Antiepilepsy Drugs.....	129
Antifibrinolytics, Haemostatics and Local Sclerosants	38
Antifibrotics.....	204
Antifungals.....	97
Antifungals Topical	62
Antihistamines	201
Antihypotensives	50
Antimalarials.....	100
Antimigraine Preparations	133
Antinausea and Vertigo Agents.....	133
Antiparasitics.....	100
Antipruritic Preparations	63
Antipsychotics.....	135
Antiretrovirals.....	106
Antirheumatoid Agents	113
Antispasmodics and Other Agents Altering Gut Motility	8
Antithrombotic Agents	41
Antithymocyte globulin (equine)	180
Antitrichomonal Agents.....	100
Antituberculotics and Antileprotics.....	100
Antulcerants.....	8
Antivirals.....	102
Anxiolytics.....	138
Anzatax.....	163
Apidra	10
Apidra SoloStar	10
Apo-Amiloride.....	53
Apo-Amlodipine	51
Apo-Amoxi.....	93
Apo-Azithromycin.....	91
Apo-Bromocriptine.....	122

249

Betoptic S.....	210	Budesonide.....	202	CareSens N Premier.....	12
Bezafibrate.....	54	Alimentary.....	6	CareSens PRO.....	13
Bezalip.....	54	Respiratory.....	201, 207	Carmellose sodium with gelatin and pectin.....	32
Bezalip Retard.....	54	Budesonide with eformoterol.....	202	Carmustine.....	156
Bicalutamide.....	172	Bumetanide.....	53	Carvedilol.....	50
Bicillin LA.....	93	Buprenorphine with naloxone.....	151	Carvedilol Sandoz.....	50
BICNU.....	156	Bupropion hydrochloride.....	152	Catapres.....	52
Bile and Liver Therapy.....	9	Burinex.....	53	Cathejell.....	123
Bitricide.....	90	Buscopan.....	8	CeeNU.....	156
Bimatoprost.....	211	Buspirone hydrochloride.....	138	Cefaclor monohydrate.....	90
Bimatoprost Actavis.....	211	Busulfan.....	156	Cefalexin.....	90
Binarex.....	172	Butacort Aqueous.....	207	Cefalexin Sandoz.....	90
Biodone.....	125	- C -			90
Biodone Extra Forte.....	125	Cabergoline.....	88	Cefazolin.....	90
Biodone Forte.....	125	Cafergot.....	133	Ceftriaxone.....	90
Bisacodyl.....	27	Cafergot S29.....	133	Cefuroxime axetil.....	90
Bisoprolol fumarate.....	50	Caffeine citrate.....	207	Celecoxib.....	112
BK Lotion.....	66	Calamine.....	63	Celecoxib Pfizer.....	112
Bleomycin sulphate.....	160	Calcipotriol.....	69	Celestone Chronodose.....	79
Blood Colony-stimulating Factors.....	44	Calcitonin.....	78	Celiprolol.....	50
Blood glucose diagnostic test meter.....	12	Calcitriol.....	34	Cellcept.....	174
Blood glucose diagnostic test strip.....	13	Calcitriol-AFT.....	34	Celol.....	50
Blood glucose test strips (visually impaired).....	13	Calcium carbonate.....	6, 35	Centrally-Acting Agents.....	52
Blood Ketone Diagnostic Test Strip.....	11	Calcium Channel Blockers.....	51	Cephalexin ABM.....	90
Bonjela.....	33	Calcium Disodium Versenate.....	214	Cerezyme.....	31
Bonvit.....	26	Calcium folinate.....	158	Cetirizine hydrochloride.....	201
Boostrix.....	237	Calcium Folate Ebewe.....	158	Cetomacrogol.....	66
Bortezomib.....	161	Calcium Folate Sandoz.....	158	Cetomacrogol with glycerol.....	66
Bosentan.....	57	Calcium gluconate.....	35	Cetuximab.....	189
Bosentan Dr Reddy's.....	57	Calcium Homeostasis.....	78	Champix.....	153
Bosentan-Mylan.....	57	Calcium polystyrene sulphonate.....	45	Charcoal.....	213
Bosvate.....	50	Calcium Resonium.....	45	Chemotherapeutic Agents.....	155
Bplex.....	33	Calogen.....	220	Chickenpox vaccine.....	247
Breo Ellipta.....	202	Calsource.....	35	Chlorafast.....	208
Brevinor 1/21.....	73	Camptosar.....	159	Chlorambucil.....	156
Brevinor 1/28.....	73	Candesartan cilexetil.....	48	Chloramphenicol.....	208
Brevinor 21.....	73	Candestar.....	48	Chlorhexidine gluconate Alimentary.....	33
Bricanyl Turbuhaler.....	203	Canesten.....	62	Dermatological.....	65
Brilinta.....	41	Capecitabine.....	158	Chloroform.....	216
Brimonidine tartrate.....	211	Capoten.....	47	Chlorothiazide.....	54
Brimonidine tartrate with timolol maleate.....	211	Capsaicin.....		Chlorpheniramine maleate.....	201
Brinov.....	158	Musculoskeletal.....	113	Chlorpromazine hydrochloride.....	135
Brinzolamide.....	210	Nervous.....	124	Chlorsig.....	208
Brolene.....	208	Captopril.....	47	Chlortalidone [Chlorthalidone].....	54
Bromocriptine mesylate.....	122	Carafate.....	9	Chlorthalidone.....	54
Brufen SR.....	112	Carbaccord.....	156	Chlorvescent.....	46
BSF Apo-Gabapentin.....	213	Carbamazepine.....	130	Choice Load 375.....	72
BSF Aripiprazole Sandoz.....	213	Carbimazole.....	83	Choice TT380 Short.....	72
BSF Tenofovir Disproxil Teva.....	213	Carbomer.....	212	Choice TT380 Standard.....	72
Buccastem.....	134	Carboplatin.....	156	Cholestyramine.....	55
		Carboplatin Ebewe.....	156	Choline salicylate with cetalkonium chloride.....	33
		Carbosorb-X.....	213	Ciclopirox olamine.....	62
		Cardinol LA.....	51	Ciclosporin.....	198
		CareSens Dual.....	12	Cilazapril.....	47
		CareSens N.....	12-13		
		CareSens N POP.....	12		

Cilazapril with hydrochlorothiazide	48	Colchicine	120	Dactinomycin [Actinomycin D]	161
Cilicaine	94	Colecalciferol	34	Daivobet	69
Cilicaine VK	94	Colestid	55	Daivonex	69
Cinacalcet	78	Colestipol hydrochloride	55	Daktarin	63
Cipflox	95	Colgout	120	Dalacin C	95
Ciprofloxacin		Colifoam	7	Dalteparin sodium	42
Infection	95	Colistin sulphomethate	95	Danazol	89
Sensory	208	Colistin-Link	95	Dantrium	121
Ciprofloxacin Teva	208	Collodion flexible	216	Dantrium S29	121
Circadin	146	Colloidal bismuth subcitrate	9	Dantrolene	121
Cisplatin	156	Colofac	8	Daonil	11
Cisplatin Ebewe	156	Coloxyl	26	Dapa-Tabs	54
Citalopram hydrobromide	128	Combigan	211	Dapsone	101
Cladribine	158	Compound electrolytes	45	Daraprim	96
Clarithromycin		Compound electrolytes with glucose [Dextrose]	45	Darunavir	108
Alimentary	8	Compound hydroxybenzoate	216	Dasatinib	166
Infection	91	Concerta	150	Daunorubicin	161
Clexane	42	Condoms	72	DBL Acetylcysteine	213
Clindamycin	95	Condyline	71	DBL Aminophylline	206
Clindamycin ABM	95	Contact-D	20	DBL Bleomycin Sulfate	160
Clinicians Renal Vit	34	Contraceptives - Hormonal	72	DBL Carboplatin	156
Clobazam	130	Contraceptives - Non-hormonal	72	DBL Cisplatin	156
Clobetasol propionate	64, 70	Copaxone	146	DBL Dacarbazine	161
Clobetasone butyrate	64	Cordarone-X	49	DBL Docetaxel	162
Clofazimine	100	Corticosteroids and Related Agents for Systemic Use	79	DBL Ergometrine	75
Clomazol		Corticosteroids Topical	64	DBL Gemcitabine	158
Dermatological	62	Cosentyx	193	DBL Gentamicin	95
Genito-Urinary	75	Cosmegen	161	DBL Leucovorin Calcium	158
Clomifene citrate	89	Coumadin	44	DBL Methotrexate Onco-Vial	159
Clomipramine hydrochloride	127	Creon 10000	25	DBL Morphine Sulphate	126
Clonazepam	129-130, 138	Creon 25000	25	DBL Morphine Tartrate	126
Clonidine	52	Crotamiton	63	DBL Naloxone Hydrochloride	213
Clonidine BNM	52	Crystaderm	62	DBL Octreotide	172
Clonidine hydrochloride	52	Curam	93	DBL Pethidine Hydrochloride	127
Clopidogrel	41	Cvite	34	DBL Vincristine Sulfate	165
Clopine	135	Cyclizine hydrochloride	134	De-Worm	90
Clopirox	136, 138	Cyclizine lactate	134	Decozol	33
Clotrimazole		Cyclogyl	211	Deferasirox	213
Dermatological	62	Cyclopentolate hydrochloride	211	Deferiprone	214
Genito-Urinary	75	Cyclophosphamide	156	Denosumab	115
Clozapine	135	Cycloserine	101	Deolate	99
Clozaril	135	Cyklokapron	40	Deoxycoformycin	164
Clustran	133	Cyproterone acetate	80	Depo-Medrol	80
Co-trimoxazole	97	Cyproterone acetate with ethinyloestradiol	74	Depo-Medrol with Lidocaine	80
Coal tar	69	Cystadane	28	Depo-Provera	74
Coal tar with allantoin, menthol, phenol and sulphur	70	Cytarabine	158	Depo-Testosterone	80
Coal tar with salicylic acid and sulphur	70	Cytotec	8	Deprim	97
Coco-Scalp	70	Cytoxan	156	DermAssist	64
Codeine phosphate				Dermol	64, 70
Extemporaneous	216			Desferal	214
Nervous	125			Desferrioxamine mesilate	214
Cogentin	122			Desmopressin acetate	88
Colaspase [L-asparaginase]	161			Desmopressin-PH&T	88
				Detection of Substances in Urine	77

- D -

Dexamethasone	Agents	65	Econazole nitrate	63
Hormone	Disopyramide phosphate	49	Efavirenz	107
Sensory	Disulfiram	152	Efavirenz with emtricitabine and	
Dexamethasone phosphate	Ditropan	76	tenofovir disoproxil	
Dexamethasone with framycetin and	Diuretics	53	fumarate	107
gramicidin	Diurin 40	53	Effient	41
Dexamethasone with neomycin	Docetaxel	162	Eformoterol fumarate	202
sulphate and polymyxin B	Docetaxel Sandoz	162	Eformoterol fumarate dihydrate	202
sulphate	Docusate sodium	26	Efudix	71
Dexamfetamine sulfate	Docusate sodium with		Egopsoryl TA	70
Dexmethsone	sennosides	26	Elaprase	29
Dextrochlorpheniramine	Dolutegravir	108	Elecare	234
maleate	Domperidone	134	Elecare LCP	234
Dextrose	Donepezil hydrochloride	151	Elelyso	31
DHC Continus	Donepezil-Rex	151	Elemental 028 Extra	225
Diabetes	Dopress	127	Elocon	65
Diabetes Management	Dornase alfa	206	Elocon Alcohol Free	65
Diacomit	Dortimopt	210	Eltrombopag	38
Diagnostic Agents	Dorzolamide hydrochloride	210	Eltroxin	83
Diamide Relief	Dorzolamide with timolol	210	EMB Fatol	101
Diamox	Dostinex	88	Emend Tri-Pack	133
Diapip	Dosulepin [Dothiepin]		EMLA	124
Diason RTH	hydrochloride	127	Emtricitabine	108
Diazepam	Dothiepin	127	Emtricitabine with tenofovir disoproxil	
Diazoxide	Doxazosin	47	fumarate	105
Dibenzyliline	Doxepin hydrochloride	128	Emtriva	108
Diclofenac Sandoz	Doxine	94	Emulsifying ointment	66
Diclofenac sodium	Doxorubicin Ebewe	162	Enalapril maleate	47
Musculoskeletal	Doxorubicin hydrochloride	162	Enbrel	174
Sensory	Doxy-50	94	Endocrine Therapy	171
Differin	Doxycycline	94	Endoxan	156
Diffiam	DP Fusidic Acid Cream	62	Enerlyte	45
Diflucan	DP Lotion	66	Engerix-B	239
Diflucan S29	DP Lotn HC	64	Enlax XR	129
Diflucortolone valerate	DP-Allopurinol	119	Enoxaparin sodium	42
Digestives Including Enzymes	Dr Reddy's Omeprazole	9	Ensure	229
Digoxin	Drugs Affecting Bone		Ensure Plus	229
Dihydrocodeine tartrate	Metabolism	113	Ensure Plus HN	228
Dilantin	Dual blood glucose and blood ketone		Ensure Plus RTH	228
Dilantin Infatab	diagnostic test meter	12	Entacapone	122
Diltiazem hydrochloride	Duocal Super Soluble Powder	219	Entapone	122
Dilzem	Duolin	203	Entecavir	103
Dimethicone	Duolin HFA	203	Entecavir Sandoz	103
Dimethyl fumarate	Durex Confidence	72	Entocort CIR	6
Dipentum	Durex Extra Safe	72	Entresto 24/26	48
Diphtheria, tetanus and pertussis	Duride	56	Entresto 49/51	48
vaccine	Dynacirc-SRO	52	Entresto 97/103	48
Diphtheria, tetanus, pertussis and	- E -		Epilim	131
polio vaccine	e-chamber La Grande	207	Epilim Crushable	131
Diphtheria, tetanus, pertussis, polio,	e-chamber Mask	207	Epilim IV	131
hepatitis B and haemophilus	e-chamber Turbo	207	Epilim S/F Liquid	131
influenzae type B vaccine	E-Mycin	92	Epilim Syrup	131
Diprosone	Ear Preparations	208	Epirubicin Ebewe	162
Diprosone OV	Ear/Eye Preparations	208	Epirubicin hydrochloride	162
Dipyridamole	Easiphen Liquid	233	Eplerenone	53
Disinfecting and Cleansing	EasyCheck	75	Epoetin alfa [Erythropoietin alfa]	38

Epoprostenol	59	Ezetimibe with simvastatin	56	Fluorometholone.....	210
Eprex	38	- F -		Fluorouracil.....	158
Eptacog alfa [Recombinant factor Vlla]	39	Factor eight inhibitor bypassing fraction.....	39	Fluorouracil Ebewe.....	158
ERA	92	Febuxostat.....	120	Fluorouracil sodium	71
Erbitux	189	Feed Thickener Karicare Aptamil.....	231	Fluoxetine hydrochloride	129
Ergometrine maleate	75	FEIBA NF	39	Flupenthixol decanoate	136
Ergonovine	75	Felo 10 ER.....	52	Flutamide.....	172
Ergotamine tartrate with caffeine	133	Felo 5 ER.....	52	Flutamide Mylan	172
Erlotinib.....	167	Felodipine.....	52	Flutamin	172
Erythrocin IV	92	Fenpaed	112	Fluticasone	202
Erythromycin ethyl succinate.....	92	Fentanyl.....	125	Fluticasone furoate with vilanterol	202
Erythromycin lactobionate	92	Fentanyl Sandoz.....	125	Fluticasone propionate	207
Erythromycin stearate.....	92	Ferinject	35	Fluticasone with salmeterol	203
Erythropoietin alfa.....	38	Ferodan	36	FML	210
Esbriet	205	Ferric carboxymaltose	35	Foban	62
Escitalopram.....	128	Feriprox	214	Folic acid	38
Escitalopram-Apotex	128	Ferro-F-Tabs	36	Food Thickeners.....	231
Eskazole	90	Ferro-tab.....	36	Foods And Supplements For Inborn Errors Of Metabolism.....	232
Estradot	81	Ferrograd.....	36	Foradil.....	202
Estradot 50 mcg	81	Ferrous fumarate	36	Forteo	117
Estroferm	81	Ferrous fumarate with folic acid.....	36	Fortini	223
Etanercept	174	Ferrous sulphate.....	36	Fortini Multi Fibre.....	223
Ethambutol hydrochloride.....	101	Ferrum H	36	Fortisip.....	229
Ethics Aspirin.....	124	Fexofenadine hydrochloride	201	Fortisip Multi Fibre	230
Ethics Aspirin EC.....	41	Fibro-vein.....	40	Fosamax.....	114-115
Ethics Enalapril.....	47	Filgrastim	44	Fosamax Plus.....	114
Ethics Lisinopril.....	47	Finasteride.....	76	Fragmin	42
Ethinylloestradiol	82	Fingolimod.....	140	Framycetin sulphate	208
Ethinylloestradiol with desogestrel	73	Firazyr.....	200	Frisium.....	130
Ethinylloestradiol with levonorgestrel	73	Flagyl.....	100	Frumil.....	54
Ethinylloestradiol with norethisterone.....	73	Flagyl-S.....	100	Frusemide.....	53
Ethosuximide	130	Flamazine.....	62	Frusemide-Claris	53
Etidronate disodium.....	116	Flecainide acetate	49	Fucicort.....	65
Etopophos	162	Fleet Phosphate Enema	27	Fucidin	97
Etoposide.....	162	Flixonase Hayfever & Allergy	207	Fucithalmic	208
Etoposide phosphate.....	162	Flixotide	202	Fungilin	33
Etravirine	107	Flixotide Accuhaler	202	Furosemide [Frusemide].....	53
Eumovate	64	Floair.....	202	fusidic acid	
Everet	131	Florinef.....	79	Dermatological.....	62, 65
Everolimus.....	198	Fluanxol.....	136	Infection	97
Evista	116	Fluarix Tetra	241	Sensory.....	208
Exelon.....	151	Flucil	93	- G -	
Exemestane.....	174	Flucloxacillin	93	Gabapentin.....	130
Exjade.....	213	Flucloxin	93	Gacet	125
Extemporaneously Compounded Preparations and Galenicals.....	216	Fluconazole	97	Galsulfase.....	28
Eye Preparations	208	Fludara Oral.....	158	Galvumet.....	11
Eylea.....	187	Fludarabine Ebewe.....	158	Galvus	11
Ezetimibe.....	55	Fludarabine phosphate.....	158	Gardasil 9	240
Ezetimibe Sandoz.....	55	Fludrocortisone acetate	79	Gastrodenol	9
		Fluids and Electrolytes	44	Gaviscon Double Strength.....	6
		Flumetasone pivalate	208	Gaviscon Infant.....	6
		Fluocortolone caproate with fluocortolone pivalate and cinchocaine.....	7	Gazyva	189
				Gefitinib	167
				Gemcitabine Ebewe	158

Gemcitabine hydrochloride.....	158	healthE Dimethicone 10%.....	66	Dermatological.....	62
Gemfibrozil.....	54	healthE Dimethicone 4% Lotion.....	67	Hydroxocobalamin.....	33
Gemzar.....	158	healthE Dimethicone 5%.....	66	Hydroxychloroquine.....	113
Genoptic.....	208	healthE Glycerol BP.....	216	Hydroxyurea.....	162
Genox.....	173	healthE Urea Cream.....	66	Hygroton.....	54
Gentamicin sulphate		Healtheries Simple Baking Mix.....	231	Hylo-Fresh.....	212
Infection.....	95	Hemastix.....	77	Hymenoptera.....	200
Sensory.....	208	Heparin sodium.....	43	Hyoscine butylbromide.....	8
Gilenya.....	140	Heparinised saline.....	43	Hyoscine hydrobromide.....	134
Ginet.....	74	Heparon Junior.....	222	Hypam.....	147
Glatiramer acetate.....	146	Hepatitis A vaccine.....	238	Hyperuricaemia and Antigout.....	119
Glibenclamide.....	11	Hepatitis B recombinant		Hypromellose.....	211
Gliclazide.....	11	vaccine.....	239	Hypromellose with dextran.....	211
Glipizide.....	11	Hepsera.....	102	Hysite.....	211
Glivec.....	167	Herceptin.....	194	- I -	
Glizide.....	11	Hexamine hippurate.....	111	Ibiamox.....	93
Glucagen Hypokit.....	9	Hiberix.....	238	Ibuprofen.....	112
Glucagon hydrochloride.....	9	Hiprex.....	111	Icatibant.....	200
Glucerna Select.....	221	Histaclear.....	201	Idarubicin hydrochloride.....	162
Glucerna Select RTH.....	221	Histafen.....	201	Idursulfase.....	29
Glucobay.....	11	Holoxan.....	156	Ifosfamide.....	156
Glucose [Dextrose].....	44	Horleys Bread Mix.....	231	Ikorel.....	57
Gluten Free Foods.....	231	Horleys Flour.....	232	Ilprost.....	60
Glycerin with sodium saccharin.....	216	Hormone Replacement Therapy -		Imatinib mesilate.....	167
Glycerin with sucrose.....	216	Systemic.....	81	Imatinib-AFT.....	167
Glycerol		HPV.....	240	Imiglucerase.....	31
Alimentary.....	27	Humalog.....	10	Imipramine hydrochloride.....	128
Extemporaneous.....	216	Humalog Mix 25.....	10	Imiquimod.....	71
Glyceryl trinitrate		Humalog Mix 50.....	10	Immune Modulators.....	108
Alimentary.....	8	Human papillomavirus (6, 11, 16, 18,		Immunosuppressants.....	174
Cardiovascular.....	56	31, 33, 45, 52 and 58) vaccine		Imuran.....	174
Glycopyrronium.....	204	[HPV].....	240	Incruse Ellipta.....	204
Glycopyrronium bromide.....	8	Humatin.....	96	Indacaterol.....	202
Glycopyrronium with		Humira.....	180	Indapamide.....	54
indacaterol.....	204	HumiraPen.....	180	Infanrix IPV.....	237
Glytrin.....	56	Humulin 30/70.....	10	Infanrix-hexa.....	238
Gold Knight.....	72	Humulin NPH.....	10	Infant Formulae.....	234
Goserelin.....	87	Humulin R.....	10	Infatrin.....	235
Gutron.....	50	Hyaluronic acid.....	212	Influenza vaccine.....	241
Gynaecological Anti-infectives.....	75	Hybloc.....	50	Influvac.....	241
- H -		Hydralazine.....	57	Influvac Tetra.....	242
Habitrol.....	153	Hydralazine hydrochloride.....	57	Inhaled Corticosteroids.....	201
Haemophilus influenzae type B		Hydrea.....	162	Inhaled Long-acting	
vaccine.....	238	Hydrocortisone		Beta-adrenoceptor Agonists.....	202
Haldol.....	136	Dermatological.....	64	Inset 30.....	21
Haldol Concentrate.....	136	Hormone.....	79	Inset II.....	23
Haldol Decanoas.....	136	Hydrocortisone acetate.....	7	Inspra.....	53
Haloperidol.....	135	Hydrocortisone and paraffin liquid		Insulin aspart.....	10
Haloperidol decanoate.....	136	and lanolin.....	64	Insulin aspart with insulin aspart	
Hamilton Sunscreen.....	70	Hydrocortisone butyrate.....	64, 70	protamine.....	10
Harvoni.....	104	Hydrocortisone with cinchocaine.....	7	Insulin glargine.....	10
Havrix.....	238	Hydrocortisone with miconazole.....	65	Insulin glulisine.....	10
Havrix Junior.....	238	Hydrocortisone with natamycin and		Insulin isophane.....	10
HBvaxPRO.....	239	neomycin.....	65	Insulin isophane with insulin	
healthE Calamine Aqueous Cream		Hydrogen peroxide		neutral.....	10
BP.....	63	Alimentary.....	33	Insulin lispro.....	10

Insulin lispro with insulin lispro protamine.....	10	Isradipine.....	52	Lanvis.....	160
Insulin neutral.....	10	Isuprel.....	57	Lanzol Relief.....	8
Insulin pen needles.....	13	Itch-Soothe.....	63	Lapatinib ditosylate.....	168
Insulin pump.....	14	Itraconazole.....	98	Largactil.....	135
Insulin pump accessories.....	19	Itrazole.....	98	Laronidase.....	29
Insulin pump cartridge.....	19	Ivermectin.....	67	Lasix.....	53
Insulin pump infusion set (steel cannula).....	20	- J -		Latanoprost.....	211
Insulin pump infusion set (steel cannula, straight insertion).....	21	Jadelle.....	74	Lax-Suppositories.....	27
Insulin pump infusion set (teflon cannula, angle insertion with insertion device).....	21	Jakavi.....	170	Lax-Tab.....	27
Insulin pump infusion set (teflon cannula, angle insertion).....	22	Jevity HiCal RTH.....	228	Laxatives.....	26
Insulin pump infusion set (teflon cannula, straight insertion with insertion device).....	23	Jevity RTH.....	228	Laxsol.....	26
Insulin pump infusion set (teflon cannula, straight insertion).....	24	Juno Pemetrexed.....	159	Ledipasvir with sofosbuvir.....	104
Insulin pump reservoir.....	25	- K -		Leflunomide.....	113
Insulin syringes, disposable with attached needle.....	14	Kaletra.....	108	Lenalidomide.....	162
Intal Forte CFC Free.....	206	Kemadrin.....	122	Letrole.....	174
Intelence.....	107	Kenacomb.....	208	Letrozole.....	174
Interferon alfa-2a.....	109	Kenacort-A 10.....	80	Leukeran FC.....	156
Interferon alfa-2b.....	109	Kenacort-A 40.....	80	Leukotriene Receptor Antagonists.....	206
Interferon beta-1-alpha.....	146	Kenalog in Orabase.....	33	Leunase.....	161
Interferon beta-1-beta.....	146	Ketocal 3:1.....	236	Leuporelin.....	87
Intra-uterine device.....	72	KetoCal 4:1.....	236	Leustatin.....	158
Intron-A.....	109	Ketoconazole.....		Levetiracetam.....	131
Invega Sustenna.....	137	Dermatological.....	70	Levetiracetam-AFT.....	131
IPOL.....	246	Infection.....	98	Levlen ED.....	73
Ipratropium bromide.....	203, 207	Ketogenic Diet.....	236	Levobunolol.....	210
Iressa.....	167	Ketoprofen.....	112	Levocabastine.....	210
Irinotecan Actavis 100.....	159	KetoSens.....	11	Levodopa with benserazide.....	122
Irinotecan Actavis 40.....	159	Ketostix.....	11	Levodopa with carbidopa.....	122
Irinotecan hydrochloride.....	159	Keytruda.....	197	Levomepromazine.....	
Irinotecan-Rex.....	159	Kindergen.....	223	hydrochloride.....	135
Iron polymaltose.....	36	Kinson.....	122	Levomepromazine maleate.....	135
ISENTRESS.....	108	Kivexa.....	107	Levonorgestrel.....	
Ismo 20.....	56	Klacid.....	91	Genito-Urinary.....	74
Ismo 40 Retard.....	56	Kliogest.....	82	Hormone.....	82
Isoniazid.....	101	Kliovance.....	82	Levothyroxine.....	83
Isoniazid with rifampicin.....	101	Kogenate FS.....	40	Lidocaine [Lignocaine].....	123-124
Isoprenaline [Isoproterenol].....	57	Konakion MM.....	41	Lidocaine [Lignocaine].....	
Isoproterenol.....	57	Konsyl-D.....	26	hydrochloride.....	124
Isoptin.....	52	Kuvan.....	30	Lidocaine [Lignocaine] with chlorhexidine.....	124
Isopto Carpine.....	211	- L -		Lidocaine [Lignocaine] with prilocaine.....	124
Isosorbide mononitrate.....	56	L-asparaginase.....	161	Lidocaine-Clarix.....	124
Isosource Standard.....	228	Labetalol.....	50	Lignocaine.....	
Isotane 10.....	61	Lacosamide.....	130	Hormone.....	80
Isotane 20.....	61	Lactulose.....	27	Nervous.....	123-124
Isotretinoin.....	61	Laevolac.....	27	Lioresal Intrathecal.....	121
Isphaghula (psyllium) husk.....	26	Lamictal.....	131	Lipazil.....	54
		Lamivudine.....	103, 108	Lipid-Modifying Agents.....	54
		Lamivudine Alphapharm.....	108	Liquigen.....	220
		Lamotrigine.....	131	Lisinopril.....	47
		Lamprene.....	100	Lithicarb FC.....	136
		Lanoxin.....	49	Lithium carbonate.....	136
		Lanoxin PG.....	49	Livostin.....	210
		Lanoxin S29.....	49	LMX4.....	124
		Lansoprazole.....	8		
		Lantus.....	10		
		Lantus SoloStar.....	10		

Locacorten-Viaform ED's.....	208	Mast Cell Stabilisers	206	Methylprednisolone aceponate.....	64
Local preparations for Anal and Rectal Disorders	7	Maxidex	209	Methylprednisolone acetate.....	80
Locasol	234	Maxitrol	209	Methylprednisolone acetate with lidocaine [Lignocaine].....	80
Locoid	64, 70	MCT oil (Nutricia).....	220	Methylxanthines.....	206
Locoid Crelo	64	Measles, mumps and rubella vaccine	244	Metoclopramide Actavis 10	134
Locoid Lipocream	64	Mebendazole.....	90	Metoclopramide hydrochloride	134
Locorten-Vioform	208	Mebeverine hydrochloride	8	Metolazone.....	53
Lodi.....	49	Medrol.....	79	Metopirone.....	89
Lodoxamide.....	210	Medroxyprogesterone acetate Genito-Urinary.....	74	Metoprolol succinate.....	50
Logem.....	131	Hormone	81-82	Metoprolol tartrate	51
Lomide	210	Medsurge.....	52	Metronidazole.....	100
Lomustine.....	156	Mefenamic acid	112	Metropolol IV Mylan.....	51
Loniten.....	57	Megestrol acetate	172	Metyrapone.....	89
Loperamide hydrochloride	6	Melatonin.....	146	Mexiletine hydrochloride.....	49
Lopinavir with ritonavir.....	108	Melphalan	157	Mexiletine Hydrochloride USP	49
Lopresor	51	Menactra.....	244	Miacalcic.....	78
Loprofin.....	233	Meningococcal (groups A, C, Y and W-135) conjugate vaccine	244	Micolette	27
Loprofin Mix.....	233	Meningococcal C conjugate vaccine	244	Miconazole	33
Lorafix.....	201	Menthol.....	63	Miconazole nitrate Dermatological	63
Loratadine.....	201	Mercaptopurine.....	159	Genito-Urinary.....	75
Lorazepam.....	138	Mercilon 28.....	73	Micreme.....	75
Lorfast.....	201	Mesalazine	7	Micreme H	65
Lormetazepam.....	146	Mesna.....	163	Microgynon 20 ED	73
Lorstat.....	55	Mestinon.....	112	Microgynon 30	73
Losartan Actavis	48	Metabolic Disorder Agents	27	Microgynon 50 ED	73
Losartan potassium	48	Metchek.....	11	Microlut.....	74
Losartan potassium with hydrochlorothiazide	48	Meterol.....	202	Midazolam	147
Lovir.....	103	Metformin hydrochloride	11	Midazolam-Claris.....	147
Lucrin Depot 1-month	87	Metformin Mylan	11	Midodrine.....	50
Lucrin Depot 3-month	87	Methadone hydrochloride	216	Minerals	35
Ludomil.....	128	Extemporaneous.....	216	Mini-Wright AFS Low Range	207
Lycinate	56	Nervous.....	125	Mini-Wright Standard.....	207
Lyderm.....	69	Methatabs.....	125	Minidiab	11
- M -		Methopt.....	211	MiniMed 640G	14
m-Eslon	126	Methotrexate.....	159	Minims Pilocarpine	211
Mabthera	191	Methotrexate Ebewe.....	159	Minims Prednisolone	210
Macrogl 3350 with potassium chloride, sodium bicarbonate and sodium chloride	27	Methotrexate Sandoz	159	Minirin	88
Macrogl 400 and propylene glycol	212	Methyl hydroxybenzoate.....	216	Mino-tabs.....	94
Madopar 125	122	Methylcellulose	216	Minocycline hydrochloride	94
Madopar 250	122	Methylcellulose with glycerin and sodium saccharin.....	216	Minomycin	94
Madopar 62.5	122	Methylcellulose with glycerin and sucrose	217	Minor Skin Infections	67
Madopar HBS.....	122	Methyldopa	53	Minoxidil.....	57
Madopar Rapid	122	Methyldopa Mylan	53	Mirena.....	82
Magnesium hydroxide	216	Methylnaltrexone bromide	27	Mirtazapine	129
Magnesium sulphate	36	Methylphenidate hydrochloride	149	Misoprostol	8
Mantoux.....	247	Methylphenidate hydrochloride extended-release	150	Mitomycin C.....	163
Maprotiline hydrochloride	128	Methylprednisolone	79	Mitozantrone	163
Marevan.....	44	Methylprednisolone (as sodium succinate).....	80	Mitozantrone Ebewe.....	163
Marine Blue Lotion SPF 50+	70			Mixtard 30.....	10
Marvelon 28.....	73			Moclobemide	128
Mask for spacer device.....	207			Modafinil	150
				Modavigil	150
				Moduretic.....	54
				Molaxole	27

Mometasone furoate.....	65	Navelbine.....	166	Norfloxacin.....	111
Monogen.....	222	Nedocromil.....	206	Noriday 28.....	74
Montelukast.....	206	Nefopam hydrochloride.....	124	Norimin.....	73
Morotocog alfa [Recombinant factor VIII].....	39	Neisvac-C.....	244	Normacol Plus.....	26
Morphine hydrochloride.....	126	Neo-B12.....	33	Normison.....	147
Morphine sulphate.....	126	Neo-Mercazole.....	83	Norpress.....	128
Morphine tartrate.....	126	Neocate Gold.....	234	Nortriptyline hydrochloride.....	128
Motetis.....	123	Neocate Junior Unflavoured.....	234	Norvir.....	108
Mouth and Throat.....	32	Neocate Junior Vanilla.....	234	NovaSource Renal.....	224
Movapo.....	122	Neocate LCP.....	234	Novatrelin.....	69
Moxifloxacin.....	95	Neocate SYNEO.....	234	NovoMix 30 FlexPen.....	10
MSUD Maxamum.....	232	Neoral.....	198	NovoRapid.....	10
Mucilaginous laxatives with stimulants.....	26	Neostigmine metilsulfate.....	112	NovoRapid FlexPen.....	10
Mucolytics.....	206	Nepro HP (strawberry).....	224	NovoRapid Penfill.....	10
Mucosoothe.....	124	Nepro HP (vanilla).....	224	NovoSeven RT.....	39
Multiple Sclerosis Treatments.....	138	Nepro HP RTH.....	224	Noxafil.....	99
Multivitamin renal.....	34	Nerisone.....	64	Nozinan.....	135
Multivitamins.....	34	Neulactil.....	136	Nuelin.....	206
Mupirocin.....	62	Neulastim.....	44	Nuelin-SR.....	206
Muscle Relaxants.....	121	NeuroTabs.....	35	Nutilis.....	231
Mvite.....	34	Nevirapine.....	107	Nutrient Modules.....	218
Myambutol.....	101	Nevirapine Alphapharm.....	107	Nutrini Energy Multi Fibre.....	223
Mycobutin.....	102	Nicorandil.....	57	Nutrini Energy RTH.....	223
MycoNail.....	62	Nicotine.....	153	Nutrini Low Energy Multi Fibre.....	225
Mycophenolate mofetil.....	174	Nicotinic acid.....	54	Nutrini RTH.....	223
Mycostatin.....	63	Nifedipine.....	52	Nutrison 800 Complete Multi Fibre.....	228
Mydiacyl.....	211	Nifuran.....	111	Nutrison Concentrated.....	230
Mylan Atenolol.....	50	Nilotinib.....	168	Nutrison Energy.....	228
Mylan Clomiphen.....	89	Nilstat.....		Nutrison Energy Multi Fibre.....	228
Myleran.....	156	Alimentary.....	33	Nutrison Multi Fibre.....	228
Myocrisin.....	113	Genito-Urinary.....	75	Nutrison Standard RTH.....	228
Myometrial and Vaginal Hormone Preparations.....	75	Infection.....	98	Nyefax Retard.....	52
Myozyme.....	27	Nintedanib.....	204	Nystatin.....	
Mysoline S29.....	131	Nipent.....	164	Alimentary.....	33
- N -		Nitrados.....	147	Dermatological.....	63
Nadolol.....	51	Nitrates.....	56	Genito-Urinary.....	75
Naglazyme.....	28	Nitrazepam.....	147	Infection.....	98
Nalcrom.....	7	Nitroderm TTS.....	56	NZB Low Gluten Bread Mix.....	231
Naloxone hydrochloride.....	213	Nitrofurantoin.....	111	- O -	
Naltracord.....	152	Nitrolingual Pump Spray.....	56	O/W Fatty Emulsion Cream.....	66
Naltrexone hydrochloride.....	152	Nivolumab.....	196	Obinutuzumab.....	189
Naphazoline hydrochloride.....	212	Nizoral.....	98	Octocog alfa [Recombinant factor VIII] (Advate).....	40
Naphcon Forte.....	212	Noctamid.....	146	Octocog alfa [Recombinant factor VIII] (Kogenate FS).....	40
Naprosyn SR 1000.....	112	Nodia.....	6	Octreotide.....	172
Naprosyn SR 750.....	112	Noflam 250.....	112	Octreotide LAR (somatostatin analogue).....	172
Naproxen.....	112	Noflam 500.....	112	Oestradiol.....	81
Nardil.....	128	Non-Steroidal Anti-Inflammatory Drugs.....	112	Oestradiol valerate.....	81
Nasal Preparations.....	206	Nonacog alfa [Recombinant factor IX].....	40	Oestradiol with norethisterone.....	82
Natalizumab.....	141	Nonacog gamma, [Recombinant Factor IX].....	40	Oestriol.....	
Natulan.....	164	Norethisterone.....		Genito-Urinary.....	75
Nausafix.....	134	Genito-Urinary.....	74	Hormone.....	82
Nausicalm.....	134	Hormone.....	82	Oestrogens.....	81
Nauzene.....	134	Norflex.....	121		

Ofev	204	OxyNorm	127	Paradigm Sure-T MMT-886	20
Oil in water emulsion	66	Oxytocin	75	Paraffin	66–67
Olanzapine	136–137	Oxytocin Apotex	75	Paraffin liquid with soft white paraffin	212
Olbetam	54	Oxytocin BNM	75	Paraffin liquid with wool fat	212
Olopatadine	212	Oxytocin with ergometrine maleate	75	Paraldehyde	129
Olsalazine	7	Ozurdex	209	Parasidose	69
Omalizumab	189	- P -			67
Omeprazole	9	Pacifen	121	Parasitocidal Preparations	67
Omeprazole actavis 10	9	Paclitaxel	163	Paritaprevir, ritonavir and ombitasvir with dasabuvir	104
Omeprazole actavis 20	9	Paclitaxel Actavis	163	Paritaprevir, ritonavir and ombitasvir with dasabuvir and ribavirin	104
Omeprazole actavis 40	9	Paclitaxel Ebewe	163	Parnate	128
Omnitrope	84	Paediatric Seravit	34	Paromomycin	96
Onbrez Breezhaler	202	Paliperidone	137	Paroxetine	129
Oncaspar	163	Pamidronate disodium	116	Paser	101
OncoTICE	180	Pamisol	116	Patanol	212
Ondansetron	134	Pancreatic enzyme	25	Paxam	138
Ondansetron ODT-DRLA	134	Pantoprazole	9	Pazopanib	169
Ondansetron ODT-ORLA	134	Panzop Relief	9	Peak flow meter	207
One-Alpha	34	Panzytrat	25	Pedialyte - Bubblegum	45
Opdivo	196	Papaverine hydrochloride	57	Pediasure	223
Ora-Blend	217	Para-amino salicylic acid	101	Pediasure RTH	223
Ora-Blend SF	216	Paracare	125	Pegaspargase	163
Ora-Plus	216	Paracare Double Strength	125	Pegasis	109
Ora-Sweet	216	Paracetamol	125	Pegasis RBV Combination Pack	109
Ora-Sweet SF	216	Paracetamol + Codeine (Relieve)	127	Pegfilgrastim	44
Orabase	32	Paracetamol with codeine	127	Pegylated interferon alfa-2a	109
Oral Supplements/Complete Diet (Nasogastric/Gastrostomy Tube Feed)	221	Paradigm 1.8 Reservoir	25	Pembrolizumab	197
Oratane	61	Paradigm 3.0 Reservoir	25	Pemetrexed	159
Orgran	232	Paradigm Mio MMT-921	23	Penicillamine	113
Orion Temozolomide	164	Paradigm Mio MMT-923	23	Penicillin G	93
Ornidazole	100	Paradigm Mio MMT-925	23	PenMix 30	10
Orphenadrine citrate	121	Paradigm Mio MMT-941	23	PenMix 40	10
Ortho-tolidine	77	Paradigm Mio MMT-943	23	PenMix 50	10
Oruvail SR	112	Paradigm Mio MMT-945	23	Pentasa	7
Osmolite RTH	228	Paradigm Mio MMT-965	23	Pentostatin [Deoxycoryformycin]	164
Other Endocrine Agents	88	Paradigm Mio MMT-975	23	Pentoxifylline [Oxpentifylline]	57
Other Oestrogen Preparations	82	Paradigm Quick-Set MMT-386	24	Peptamen Junior	223
Other Progestogen Preparations	82	Paradigm Quick-Set MMT-387	24	Peptisoothe	8
Other Skin Preparations	71	Paradigm Quick-Set MMT-396	24	Peptisorb	225
Ovestin		Paradigm Quick-Set MMT-397	24	Perhexiline maleate	52
Genito-Urinary	75	Paradigm Quick-Set MMT-398	24	Pericyazine	136
Hormone	82	Paradigm Quick-Set MMT-399	24	Perindopril	47
Ox-Pam	138	Paradigm Silhouette MMT-368	22	Perjeta	191
Oxallicord	157	Paradigm Silhouette MMT-377	22	Permethrin	69
Oxaliplatin	157	Paradigm Silhouette MMT-378	22	Perrigo	71
Oxaliplatin Actavis 100	157	Paradigm Silhouette MMT-381	22	Pertuzumab	191
Oxaliplatin Actavis 50	157	Paradigm Silhouette MMT-382	22	Peteha	101
Oxaliplatin Ebewe	157	Paradigm Silhouette MMT-383	22	Pethidine hydrochloride	127
Oxazepam	138	Paradigm Silhouette MMT-384	22	Pevaryl	63
Oxis Turbuhaler	202	Paradigm Sure-T MMT-864	20	Pexsig	52
Oxpentifylline	57	Paradigm Sure-T MMT-866	20	Pfizer Exemestane	174
Oxybutynin	76	Paradigm Sure-T MMT-874	20	Pharmacy Health Sorbolene with Glycerin	66
Oxycodone hydrochloride	127	Paradigm Sure-T MMT-876	20		
		Paradigm Sure-T MMT-884	20		

Pharmacy Services.....	213	Postinor-1	74	Provera.....	81
Pheburane.....	30	Potassium chloride.....	44, 46	Provera HD.....	82
Phenelzine sulphate.....	128	Potassium citrate.....	76	PSM Citalopram	128
Phenergan Elixir.....	201	Potassium iodate.....	35	Psoriasis and Eczema Preparations	69
Phenobarbitone.....	131	Povidone iodine.....	67	PTU.....	83
Phenobarbitone sodium Extemporaneous.....	217	Pradaxa.....	43	Pulmicort Turbuhaler	201
Nervous.....	147	Pramipexole hydrochloride.....	122	Pulmocare.....	221
Phenothrin.....	69	Prasugrel.....	41	Pulmozyme.....	206
Phenoxybenzamine hydrochloride.....	47	Pravastatin.....	55	Puri-nethol.....	159
Phenoxyethylpenicillin (Penicillin V).....	94	Praziquantel.....	90	Pyrazinamide.....	101
Phenytion sodium.....	129, 131	Prazosin.....	47	Pyridostigmine bromide.....	112
Phlexy 10.....	233	Pred Forte.....	210	Pyridoxine hydrochloride	33
Phosphate-Sandoz.....	45	Prednisolone.....	80	Pyrimethamine.....	96
Phosphorus.....	45	Prednisolone acetate.....	210	Pytazen SR.....	41
Phytomenadione.....	41	Prednisolone sodium phosphate.....	210	- Q -	
Pilocarpine hydrochloride	211	Prednisolone-AFT.....	210	Q 300.....	100
Pimafucort.....	65	Prednisone.....	80	Questran-Lite.....	55
Pindolol.....	51	Pregabalin.....	131	Questran-Lite S29	55
Pine tar with trolamine laurilsulfate and fluorescein.....	70	Pregabalin Pfizer.....	131	Quetapel.....	136
Pinetarsol.....	70	Pregnancy Tests - hCG Urine	75	Quetiapine.....	136
Pioglitazone.....	11	Premarin.....	81	Quick-Set MMT-390	24
Piportil.....	137	Prevenar 13.....	245	Quick-Set MMT-391	24
Pipothiazine palmitate.....	137	Prezista.....	108	Quick-Set MMT-392	24
Pirfenidone.....	205	Priadel.....	136	Quick-Set MMT-393	24
Pizotifen.....	133	Primacin.....	100	Quinapril.....	48
PKU Anamix Infant.....	233	Primaquine phosphate.....	100	Quinapril with hydrochlorothiazide	48
PKU Anamix Junior.....	233	Primidone.....	131	Quinine sulphate.....	100
PKU Anamix Junior LQ.....	233	Primolut N.....	82	Qvar.....	201
PKU Lophlex LQ 10.....	233	Priorix.....	244	- R -	
PKU Lophlex LQ 20.....	233	Probenecid.....	121	RA-Morph.....	126
PKU Lophlex Powder.....	233	Probenecid-AFT.....	121	Raloxifene hydrochloride	116
PKU Lophlex Sensation 20.....	233	Procaine penicillin.....	94	Raltegravir potassium.....	108
Plaquenil.....	113	Procarbazine hydrochloride.....	164	Ramipex.....	122
Plendil ER.....	52	Prochlorperazine	134	Ranbaxy-Cefaclor.....	90
Pneumococcal (PCV10) conjugate vaccine	244	Proctosedyl.....	7	Ranitidine.....	8
Pneumococcal (PCV13) conjugate vaccine	245	Procur.....	80	Ranitidine Relief	8
Pneumococcal (PPV23) polysaccharide vaccine	246	Procydiline hydrochloride.....	122	Rapamune.....	199
Pneumovax 23.....	246	Procytox.....	156	Reandron 1000.....	81
Podophyllotoxin.....	71	Progesterone.....	82	Recombinant factor IX.....	40
Polaramine.....	201	Progicem.....	9	Recombinant factor VIIa.....	39
Poliomyelitis vaccine	246	Proglycem.....	9	Recombinant factor VIII	39-40
Poloxamer.....	26	Prodynova.....	81	Rectogesic.....	8
Poly-Gel.....	212	Prokinex.....	134	Redipred.....	80
Poly-Tears.....	211	Prolia.....	115	Refresh Night Time.....	212
Poly-Visc.....	212	Promethazine hydrochloride.....	201	Relieve.....	112
Polycal.....	218	Promethazine theoclate.....	134	Relistor.....	27
Polyvinyl alcohol.....	212	Propafenone hydrochloride	49	Renilon 7.5.....	224
Ponstan.....	112	Propamidine isethionate.....	208	Resonium-A.....	46
Posaconazole.....	99	Propranolol.....	51	Resource Beneprotein.....	220
		Propylene glycol.....	217	Resource Diabetic.....	221
		Propylthiouracil.....	83	Respigen.....	203
		Protaphane.....	10	Respiratory Devices.....	207
		Protaphane Penfill.....	10	Respiratory Stimulants	207
		Protifar.....	220	Retinol palmitate.....	212
		Protionamide.....	101		

ReTrieve.....	61	bromide.....	203	Respiratory.....	206
Retrovir.....	108	Salicylic acid.....	70	Sodium citrate with sodium lauryl	
Revlimid.....	162	Salmeterol.....	202	sulphoacetate.....	27
Revolade.....	38	Sandomigran.....	133	Sodium citro-tartrate.....	76
Rexacrom.....	210	Sandomigran S29.....	133	Sodium cromoglicate	
RexAir.....	203	Sandostatin LAR.....	172	Alimentary.....	7
Reyataz.....	108	Sapropterin dihydrochloride.....	30	Respiratory.....	206
Ribomustin.....	155	Scalp Preparations.....	70	Sensory.....	210
Ricit.....	76	Scopoderm TTS.....	134	Sodium fluoride.....	35
Rifabutin.....	102	Sebizole.....	70	Sodium Fusidate [fusidic acid]	
Rifadin.....	102	Secukinumab.....	193	Dermatological.....	62
Rifampicin.....	102	Sedatives and Hypnotics.....	146	Infection.....	97
Rifaximin.....	9	Seebri Breezhaler.....	204	Sensory.....	208
Rifinah.....	101	Selegiline hydrochloride.....	122	Sodium hyaluronate [Hyaluronic	
Rilutek.....	123	Senna.....	27	acid].....	212
Riluzole.....	123	Senokot.....	27	Sodium nitroprusside.....	11
Riodine.....	67	Sensipar.....	78	Sodium phenylbutyrate.....	30
Risedronate Sandoz.....	117	SensoCard.....	13	Sodium polystyrene sulphonate.....	46
Risedronate sodium.....	117	Serenace.....	135	Sodium tetradecyl sulphate.....	40
Risperdal Consta.....	138	Seretide.....	203	Sodium valproate.....	131
Risperidone.....	136, 138	Seretide Accuhaler.....	203	Sofradex.....	208
Risperon.....	136	Serevent.....	202	Soframycin.....	208
Ritalin.....	149	Serevent Accuhaler.....	202	Solian.....	135
Ritalin LA.....	150	Serophene.....	89	Solifenacin Mylan.....	77
Ritalin SR.....	149	Sertraline.....	129	Solifenacin succinate.....	77
Ritonavir.....	108	Sevredol.....	126	Solu-Cortef.....	79
Rituximab.....	191	Sex Hormones Non		Solu-Medrol.....	80
Rivaroxaban.....	43	Contraceptive.....	80	Solu-Medrol-Act-O-Vial.....	80
Rivastigmine.....	151	Shield 49.....	72	Somatropin (Omnitrope).....	84
Rivotril.....	129-130	Shield Blue.....	72	Sotalol.....	51
RIXUBIS.....	40	Shield XL.....	72	Spacer device.....	207
Rizamelt.....	133	shingles vaccine.....	247	Span-K.....	46
Rizatriptan.....	133	Sildenafil.....	59	Spiolto Respimat.....	204
Roferon-A.....	109	Silhouette MMT-371.....	22	Spiractin.....	53
Rolin.....	173	Silhouette MMT-373.....	22	Spiriva.....	204
Ropinirole hydrochloride.....	122	Siltuximab.....	194	Spiriva Respimat.....	204
Rotarix.....	246	Simvastatin.....	55	Spironolactone.....	53
Rotavirus oral vaccine.....	246	Simvastatin Mylan.....	55	Sporanox.....	98
Roxane		Sinemet.....	122	Sprycel.....	166
Alimentary.....	6	Sinemet CR.....	122	Staphlex.....	93
Cardiovascular.....	51	Sirolimus.....	199	Stemetil.....	134
Roxithromycin.....	92	Siterone.....	80	SteroClear.....	207
Rubifen.....	149	Slow-Lopresor.....	51	Stesolid.....	129
Rubifen SR.....	149	Smith BioMed Rapid Pregnancy		Stimulants/ADHD Treatments.....	148
Rulide D.....	92	Test.....	75	Stiripentol.....	131
Ruxolitinib.....	170	Sodibic.....	46	Stocrin.....	107
Rythmodan.....	49	Sodium acid phosphate.....	27	Stomahesive.....	32
Rytmonorm.....	49	Sodium alginate.....	6	Strattera.....	148
- S -		Sodium aurothiomalate.....	113	Stromectol.....	67
Sabril.....	132	Sodium benzoate.....	30	Suboxone.....	151
Sacubitril with valsartan.....	48	Sodium bicarbonate		Sucralfate.....	9
SalAir.....	203	Blood.....	45-46	Sulfadiazine Silver.....	62
Salazopyrin.....	7	Extemporaneous.....	217	Sulfadiazine sodium.....	97
Salazopyrin EN.....	7	Sodium calcium edetate.....	214	Sulfasalazine.....	7
Salbutamol.....	203	Sodium chloride		Sulindac.....	112
Salbutamol with ipratropium		Blood.....	45	Sulphur.....	70

Sulprix.....	135	Terazosin.....	47	Trandate.....	50
Sumatriptan.....	133	Terbinafine.....	99	Tranexamic acid.....	40
Sunitinib.....	170	Terbutaline sulphate.....	203	Tranlycypromine sulphate.....	128
Sunscreens.....	70	Teriflunomide.....	143	Trastuzumab.....	194
Sunscreens, proprietary.....	70	Teriparatide.....	117	Travatan.....	211
Sure-T MMT-863.....	20	Testosterone.....	80	Travoprost.....	211
Sure-T MMT-865.....	20	Testosterone cipionate.....	80	Travopt.....	211
Sure-T MMT-873.....	20	Testosterone esters.....	80	Treatments for Dementia.....	151
Sure-T MMT-875.....	20	Testosterone undecanoate.....	81	Treatments for Substance Dependence.....	151
Sure-T MMT-883.....	20	Tetrabenazine.....	123	Trental 400.....	57
Sure-T MMT-885.....	20	Tetrabromophenol.....	77	Tretinoin.....	
Sustagen Diabetic.....	221	Tetracosactrin.....	80	Dermatological.....	61
Sustagen Hospital Formula Active.....	229	Tetracyclin Wolff.....	94	Oncology.....	165
Sustanon Ampoules.....	80	Tetracycline.....	94	Trexate.....	159
Sutent.....	170	Thalidomide.....	165	Triamcinolone acetonide Alimentary.....	33
Sylvant.....	194	Thalomid.....	165	Dermatological.....	65
Symbicort Turbuhaler 100/6.....	202	Theophylline.....	206	Hormone.....	80
Symbicort Turbuhaler 200/6.....	202	Thiamine hydrochloride.....	33	Triamcinolone acetonide with gramicidin, neomycin and nystatin Dermatological.....	65
Symbicort Turbuhaler 400/12.....	202	THIO-TEPA.....	157	Sensory.....	208
Symmetrel.....	122	Thioguanine.....	160	Triazolam.....	147
Sympathomimetics.....	56	Thiotepa.....	157	Trichozole.....	100
Synacthen.....	80	Thymol glycerin.....	33	Triclosan.....	65
Synacthen Depot.....	80	Thyroid and Antithyroid Agents.....	83	Trimeprazine tartrate.....	201
Synflorix.....	244	Ticagrelor.....	41	Trimethoprim.....	97
Synthroid.....	83	Tilade.....	206	Trimethoprim with sulphamethoxazole [Co-trimoxazole].....	97
Syntometrine.....	75	Tilcotil.....	112	Trisequens.....	82
Syrup (pharmaceutical grade).....	217	Timolol Cardiovascular.....	51	Trisul.....	97
Systane Unit Dose.....	212	Sensory.....	210	Trophic Hormones.....	84
- T -		Timoptol XE.....	210	Tropicamide.....	211
Tacrolimus.....	199	Tiotropium bromide.....	204	Trusopt.....	210
Tacrolimus Sandoz.....	199	Tiotropium bromide with olodaterol.....	204	TruSteel.....	21
Taliglucerase alfa.....	31	Tivicay.....	108	Truvada.....	105
Tambocor.....	49	TMP.....	97	Tuberculin PPD [Mantoux] test.....	247
Tambocor CR.....	49	TOBI.....	97	Tubersol.....	247
Tamoxifen citrate.....	173	Tobramycin Infection.....	97	Two Cal HN.....	231
Tamoxifen Sandoz.....	173	Sensory.....	209	Two Cal HN RTH.....	230
Tamsulosin hydrochloride.....	76	Tobramycin Mylan.....	97	Tykerb.....	168
Tamsulosin-Rex.....	76	Tobrex.....	209	Tysabri.....	141
Tandem Cartridge.....	19	Tofranal.....	128	- U -	
Tandem t:slim X2.....	14	Tofrasil s29.....	128	Ultibro Breezhaler.....	204
Tap water.....	217	Tolcapone.....	122	Ultraproct.....	7
Tarceva.....	167	Tolterodine.....	77	Umeclidinium.....	204
Tasigna.....	168	Topamax.....	132	Umeclidinium with vilanterol.....	204
Tasmar.....	122	Topical Products for Joint and Muscular Pain.....	113	Univent.....	203, 207
Tecfidera.....	138	Topiramate.....	132	Ural.....	76
Tegretol.....	130	Topiramate Actavis.....	132	Urea.....	66
Tegretol CR.....	130	Total parenteral nutrition (TPN).....	45	Urex Forte.....	53
Telfast.....	201	TPN.....	45	Urinary Agents.....	76
Temazepam.....	147	Tramadol hydrochloride.....	127	Urinary Tract Infections.....	111
Temizole 20.....	164	Tramal SR 100.....	127	Uromitexan.....	163
Temozolomide.....	164	Tramal SR 150.....	127		
Tenofovir disoproxil.....	103	Tramal SR 200.....	127		
Tenofovir Disoproxil Teva.....	103				
Tenoxicam.....	112				
Tepadina.....	157				

Ursodeoxycholic acid.....	25	VitA-POS.....	212	Zista.....	201
Ursosan.....	25	Vitabdeck.....	34	Zithromax.....	91
Utrogestan.....	82	Vitadol C.....	33	Zoladex.....	87
- V -					
Vaccinations.....	237	Vital.....	225	Zoledronic acid	
Vaclovir.....	103	Vitamin A with vitamins D and C.....	33	Hormone.....	78
Valaciclovir.....	103	Vitamin B complex.....	33	Musculoskeletal.....	117
Valcyte.....	103	Vitamin B6 25.....	33	Zoledronic acid Mylan.....	78
Valganciclovir.....	103	Vitamins.....	33-34	Zometa.....	78
Vallergan Forte.....	201	Vivonex TEN.....	225	Zopiclone.....	147
Vancomycin.....	97	Volibris.....	57	Zopiclone Actavis.....	147
Vannair.....	202	Voltaren.....	112	Zostavax.....	247
Varenicline tartrate.....	153	Voltaren D.....	112	Zostrix.....	113
Varicella vaccine [Chickenpox		Voltaren Ophtha.....	209	Zostrix HP.....	124
vaccine].....	247	Volumatic.....	207	Zuclopenthixol decanoate.....	138
Varicella zoster virus [Oka strain] live		Voriconazole.....	99	Zuclopenthixol hydrochloride.....	136
attenuated vaccine [shingles		Vosol.....	208	Zusdone.....	136
vaccine].....	247	Votrient.....	169	Zyban.....	152
Varilrix.....	247	Vttack.....	99	Zypine.....	136
Various.....	213	- W -			
Vasodilators.....	57	Warfarin sodium.....	44	Zypine ODT.....	136
Vasopressin Agonists.....	88	Wart Preparations.....	71	Zyprexa Relprevv.....	137
Vedafil.....	59	Wasp venom allergy treatment.....	200	Zytiga.....	171
Velcade.....	161	Water			
Veletri.....	59	Blood.....	45		
Venlafaxine.....	129	Extemporaneous.....	217		
Venomil.....	200	Wool fat with mineral oil.....	66		
Ventavis.....	60	- X -			
Ventolin.....	203	Xarelto.....	43		
Vepesid.....	162	Xifaxan.....	9		
Verapamil hydrochloride.....	52	XMET Maxamum.....	232		
Vergo 16.....	133	Xolair.....	189		
Vermox.....	90	XP Maxamaid.....	233		
Verpamil SR.....	52	XP Maxamum.....	233		
Vesanoid.....	165	Xylocaine.....	124		
Vesicare.....	77	Xylocaine 2% Jelly.....	123		
Vexazone.....	11	Xyntha.....	39		
Vfend.....	99	- Z -			
Viaderm KC.....	65	Zantac.....	8		
Vidaza.....	157	Zapril.....	47		
Viekira Pak.....	104	Zarontin.....	130		
Viekira Pak-RBV.....	104	Zaroxolyn.....	53		
Vigabatrin.....	132	Zarzio.....	44		
Vildagliptin.....	11	Zavedos.....	162		
Vildagliptin with metformin		Zeffix.....	103		
hydrochloride.....	11	Zeldox.....	136		
Vimpat.....	130	Zetlam.....	103		
Vinblastine sulphate.....	165	Ziagen.....	107		
Vincristine sulphate.....	165	Zidovudine [AZT].....	108		
Vinorelbine.....	166	Zidovudine [AZT] with			
Vinorelbine Ebewe.....	166	lamivudine.....	108		
Viramune Suspension.....	107	Zimybe.....	56		
ViruPOS.....	208	Zinc and castor oil.....	66		
Vistil.....	212	Zinc sulphate.....	36		
Vistil Forte.....	212	Zincaps.....	36		
Vit.D3.....	34	Zinnat.....	90		
		Ziprasidone.....	136		

















