

Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to [Section H](#) of the Pharmaceutical Schedule. For community funding, see the [Special Authority Criteria](#).

**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

**Aflibercept**

**INITIATION – Wet Age Related Macular Degeneration**

Re-assessment required after 3 months

**Prerequisites** (tick boxes where appropriate)

- Prescribed by, or recommended by an ophthalmologist or nurse practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- Wet age-related macular degeneration (wet AMD)  
or  
 Polypoidal choroidal vasculopathy  
or  
 Choroidal neovascular membrane from causes other than wet AMD

and

- 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

- 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

**CONTINUATION – Wet Age Related Macular Degeneration**

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

- Prescribed by, or recommended by an ophthalmologist or nurse practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- 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

I confirm that the above details are correct:

Signed: ..... Date: .....

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**PRESCRIBER**

**PATIENT:**

Name: .....

Ward: ..... NHI: .....

**Aflibercept - continued**

**INITIATION – Diabetic Macular Oedema**

Re-assessment required after 4 months

**Prerequisites** (tick boxes where appropriate)

- Prescribed by, or recommended by an ophthalmologist or nurse practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- 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

**CONTINUATION – Diabetic Macular Oedema**

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

- Prescribed by, or recommended by an ophthalmologist or nurse practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- There is stability or two lines of Snellen visual acuity gain  
and  
 There is structural improvement on OCT scan (with reduction in intra-retinal cysts, central retinal thickness, and sub-retinal fluid)  
and  
 Patient's vision is 6/36 or better on the Snellen visual acuity score  
and  
 There is no centre-involving sub-retinal fibrosis or foveal atrophy  
and  
 After each consecutive 12 months treatment with aflibercept, patient has retrialled with at least one injection of bevacizumab and had no response

I confirm that the above details are correct:

Signed: ..... Date: .....