

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

PATIENT:

Name:

Ward: 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: