

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: .....

**Ticagrelor**

**INITIATION**

**Prerequisites** (tick box where appropriate)

- Restricted to treatment of acute coronary syndromes specifically for patients who have recently (within the last 60 days) been diagnosed with an ST-elevation or a non-ST-elevation acute coronary syndrome, and in whom fibrinolytic therapy has not been given in the last 24 hours and is not planned

**INITIATION – thrombosis prevention neurological stenting**

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

- Patient has had a neurological stenting procedure\* in the last 60 days  
or  
 Patient is about to have a neurological stenting procedure performed\*

and

- Patient has demonstrated clopidogrel resistance using the P2Y12 (VerifyNow) assay or another appropriate platelet function assay and requires antiplatelet treatment with ticagrelor

or

- Clopidogrel resistance has been demonstrated by the occurrence of a new cerebral ischemic event  
or  
 Clopidogrel resistance has been demonstrated by the occurrence of transient ischemic attack symptoms referable to the stent.

**CONTINUATION – thrombosis prevention neurological stenting**

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

- Patient is continuing to benefit from treatment  
and  
 Treatment continues to be clinically appropriate

**INITIATION – Percutaneous coronary intervention with stent deployment**

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

- Patient has undergone percutaneous coronary intervention  
and  
 Patient has had a stent deployed in the previous 4 weeks  
and  
 Patient is clopidogrel-allergic\*\*

**INITIATION – Stent thrombosis**

**Prerequisites** (tick box where appropriate)

- Patient has experienced cardiac stent thrombosis whilst on clopidogrel

**INITIATION – Myocardial infarction**

Re-assessment required after 1 week

**Prerequisites** (tick box where appropriate)

- For short term use while in hospital following ST-elevated myocardial infarction

I confirm that the above details are correct:

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

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**PRESCRIBER**

**PATIENT:**

Name: .....

Name: .....

Ward: .....

NHI: .....

**Ticagrelor** - *continued*

Note: Indications marked with \* are unapproved indications.

Note: 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

HOSPITAL

I confirm that the above details are correct:

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