Pharmaceutical Management Agency
New Zealand
Pharmaceutical Schedule

Section H Update

for Hospital Pharmaceuticals

January 2026

PHARMAC
TE PĀTAKA WHAIORANGA

Contents

Summary of decisions
EFFECTIVE 1 JANUARY 2026

- Aciclovir (Aciclovir Injection DBL) inj 250 mg vial – new listing
- Adenosine (Adenosine Baxter) inj 3 mg per ml, 10 ml vial – amended restriction criteria
- Ambrisentan (Ambrisentan Viatris) tab 5 mg and 10 mg – amended restriction criteria
- Aripiprazole (Abilify Maintena) inj 300 mg and 400 mg vial – new Pharmacode listing
- Aripiprazole (Abilify Maintena) inj 300 mg and 400 mg vial – Pharmacode 2680394 and 2680408 to be delisted 1 July 2026
- Atorvastatin (Lorstat) tab 80 mg – new listing
- Bisacodyl (Bisacodyl Viatris) tab 5 mg – price increase
- Bosentan (Bosentan Dr Reddy's) tab 62.5 mg and 125 mg – amended restriction criteria
- Carmellose sodium eye drops 0.5%, eye drops 0.5%, single dose, eye drops 1% and eye drops 1%, single dose – amended chemical name
- Colchicine (Colgout) tab 500 mcg – price increase
- Dimethicone (healthE Dimethicone 4% Lotion) lotn 4%, 200 ml – price increase and addition of PSS
- Dimethicone (HydraLock) crm 5% pump bottle, 460 g – new listing and addition of PSS
- Dimethicone (healthE Dimethicone 5%) crm 5% pump bottle, 460 g – to be delisted 1 June 2026
- Dimethicone (healthE Dimethicone 5%) crm 5% tube, 100 g – price increase and addition of PSS
- Emtricitabine with tenofovir disoproxil (Tenofovir Disoproxil Emtricitabine Mylan) tab 200 mg with tenofovir disoproxil 245 mg (300 mg as a fumarate) – new listing
- Enalapril maleate (Acetec) tab 5 mg, 10 mg and 20 mg – price increase
- Epoprostenol (Veletri) inj 500 mcg and 1.5 mg vial – amended restriction criteria
- Ezetimibe with simvastatin (Zimybe) tab 10 mg with simvastatin 10 mg, tab 10 mg with simvastatin 20 mg, tab 10 mg with simvastatin 40 mg and tab 10 mg with simvastatin 80 mg – price increase
- Glatiramer acetate (Copaxone) inj 40 mg prefilled syringe – price increase
- Glucose [dextrose] (Fresenius Kabi) inj 5%, 100 ml, 250 ml, 500 ml and 1,000 ml bag – price increase
- Iloprost (Vebulis) nebuliser soln 10 mcg per ml, 2 ml – amended restriction criteria
- Iron polymaltose (Ferrosig) inj 50 mg per ml, 2 ml ampoule – price increase
- Ketoprofen (Oruvail SR) cap long-acting 200 mg – to be delisted 1 October 2026

Summary of decisions – effective 1 January 2026 (continued)

- Loratadine (Loratadine Noumed) tab 10 mg – new listing and addition of PSS
- Loratadine (Lorafix) tab 10 mg – price increase and to be delisted 1 June 2026
- Levonorgestrel (Levonorgestrel-1 (Lupin)) tab 1.5 mg – new listing and addition of PSS
- Levonorgestrel (Levonorgestrel BNM) tab 1.5 mg – to be delisted 1 June 2026
- Losartan potassium with hydrochlorothiazide (Arrow-Losartan & Hydrochlorothiazide) tab 50 mg with hydrochlorothiazide 12.5 mg – price increase
- Methenamine (hexamine) hippurate (Hiprex) tab 1 g – new listing
- Multivitamins (Mvite) tab (BPC cap strength) – price increase
- Omeprazole (Omezol IV) inj 40 mg vial – price increase
- Patent blue V (InterPharma) inj 2.5%, 5 ml prefilled syringe – price increase
- Plerixafor (Mozobil) inj 20 mg per ml, 1.2 ml vial – amended restriction criteria
- Ropinirole hydrochloride (Ropin) tab 0.25 mg, 1 mg, 2 mg and 5 mg – price increase
- Secukinumab (Cosentyx) inj 150 mg per ml, 1 ml prefilled syringe – new Pharmacode listing
- Secukinumab (Cosentyx) inj 150 mg per ml, 1 ml prefilled syringe – Pharmacode 2554712 delisted 1 January 2026
- Sildenafil tab 25 mg, 50 mg and 100 mg (Vedafil), and inj 0.8 mg per ml, 12.5 ml vial – amended restriction criteria
- Sodium chloride irrigation soln 0.9%, 30 ml ampoule (InterPharma) and irrigation soln 0.9%, 250 ml bottle (Fresenius Kabi) – price increase
- Sodium hyaluronate [hyaluronic acid] (Healon GV) inj 14 mg per ml, 0.85 ml syringe – delisted 1 January 2026
- Teriparatide (Teriparatide – Teva) inj 250 mcg per ml, 2.4 ml – price increase
- Varenicline tartrate (Pharmacor Varenicline) tab 0.5 mg × 11 and 1 mg × 42 and tab 1 mg – new listing and addition of PSS
- Varenicline tartrate (Champix) tab 0.5 mg × 11 and 1 mg × 42 and tab 1 mg – to be delisted 1 June 2026
- Vigabatrin (Sabril) powder for oral soln 500 mg per sachet – to be delisted 1 May 2026
- Water (Fresenius Kabi) irrigation soln, 250 ml bottle – price increase
- Zinc sulphate (Rugby) cap 220 mg (50 mg elemental) – new listing

		Price (ex man. Excl. GST) $	Per	Brand or Generic Manufacturer

Section H changes to Part II

Effective 1 January 2026

ALIMENTARY TRACT AND METABOLISM

8 OMEPRAZOLE (↑ price)
Inj 40 mg vial ..... 17.09 5 Omezol IV

16 BISACODYL (↑ price)
Tab 5 mg ..... 10.00 200 Bisacodyl Viatris

24 IRON POLYMALTOSE (↑ price)
Inj 50 mg per ml, 2 ml ampoule ..... 41.75 5 Ferrosig

25 ZINC SULPHATE (new listing)
Cap 220 mg (50 mg elemental) ..... 29.14 100 Rugby

27 MULTIVITAMINS (↑ price)
Tab (BPC cap strength) ..... 24.00 1,000 Mvite

BLOOD AND BLOOD FORMING ORGANS

40 PLERIXAFOR (amended restriction criteria)
➔ Inj 20 mg per ml, 1.2 ml vial ..... 8,740.00 1 Mozobil

Restricted
Initiation – stem cell transplant
Haematologist
Limited to 3 days treatment
All of the following:
1 Either:
1.1 Patient is to undergo stem cell transplantation; **or** ~~and~~
1.2 Patient is a donor for stem cell transplantation; and
2 Patient has not had **more than one** ~~a~~ previous unsuccessful mobilisation attempt with plerixafor; and
3 Any of the following:
3.1 Both:
3.1.1 Patient is undergoing G-CSF mobilisation; and
3.1.2 Either:
3.1.2.1 Has a suboptimal peripheral blood CD34 count of less than or equal to ~~1~~**20** $\times$ 10^6/L on day 5 after 4 days of G-CSF treatment; or
3.1.2.2 Efforts to collect $> 1 \times 10^6$ CD34 cells/kg have failed after one apheresis procedure; or
3.2 Both:
3.2.1 Patient is undergoing chemotherapy and G-CSF mobilisation; and
3.2.2 Any of the following:
3.2.2.1 Both:
3.2.2.1.1 Has rising white blood cell counts of $>$ ~~5~~ **2** $\times$ 10^9/L; and
3.2.2.1.2 Has a suboptimal peripheral blood CD34 count of less than or equal to ~~1~~**20** $\times$ 10^6/L; or
3.2.2.2 Efforts to collect $> 1 \times 10^6$ CD34 cells/kg have failed after one apheresis procedure; or
3.2.2.3 The peripheral blood CD34 cell counts are decreasing before the target has been received; or
3.3 A previous mobilisation attempt with G-CSF or G-CSF plus chemotherapy has failed.

		Price (ex man. Excl. GST) $	Per	Brand or Generic Manufacturer

Changes to Section H Part II – effective 1 January 2026 (continued)

41 GLUCOSE [DEXTROSE] (↑ price)

Inj 5%, 1,000 ml bag	53.10	10	Fresenius Kabi
Inj 5%, 100 ml bag	97.00	50	Fresenius Kabi
Inj 5%, 250 ml bag	63.00	30	Fresenius Kabi
Inj 5%, 500 ml bag	67.40	20	Fresenius Kabi

CARDIOVASCULAR SYSTEM

44 ENALAPRIL MALEATE (↑ price)

Tab 5 mg	4.25	90	Acetec
Tab 10 mg	5.50	90	Acetec
Tab 20 mg	6.50	90	Acetec

45 LOSARTAN POTASSIUM WITH HYDROCHLOROTHIAZIDE (↑ price)

Tab 50 mg with hydrochlorothiazide 12.5 mg	4.31	30	Arrow-Losartan & Hydrochlorothiazide

46 ADENOSINE (amended restriction criteria)

➔ Inj 3 mg per ml, 10 ml vial – **5% DV Dec-24 to 2027**	100.00	5	**Adenosine Baxter**

Restricted
Initiation
For use in cardiac catheterisation, **myocardial perfusion scans**, electrophysiology and MRI.

51 ATORVASTATIN (new listing)

Tab 80 mg – **5% DV Dec-24 to 2027**	1.52	30	**Lorstat**

53 EZETIMIBE WITH SIMVASTATIN (↑ price)

Tab 10 mg with simvastatin 10 mg	11.86	30	Zimybe
Tab 10 mg with simvastatin 20 mg	12.55	30	Zimybe
Tab 10 mg with simvastatin 40 mg	11.55	30	Zimybe
Tab 10 mg with simvastatin 80 mg	14.27	30	Zimybe

55 AMBRISENTAN (amended restriction criteria)

➔ Tab 5 mg – **5% DV Dec-23 to 2026**	200.00	30	**Ambrisentan Viatris**
➔ Tab 10 mg – **5% DV Dec-23 to 2026**	200.00	30	**Ambrisentan Viatris**

Restricted
Initiation – PAH monotherapy
Respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist
Limited to 6 months treatment
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 2003) clinical classifications; and
3 PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV; and
4 Any of the following:
  4.1 All of the following:
    4.1.1 PAH has been confirmed by right heart catheterisation; and
    4.1.2 A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair); and
    4.1.3 A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg; and
    4.1.4 Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm^{-5}); and
    4.1.5 Any of the following:

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Changes to Section H Part II – effective 1 January 2026 (continued)

continued...

4.1.5.1 PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH ~~(see note below for link to these guidelines) †~~; or
4.1.5.2 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**; or
4.1.5.3 Patient has PAH other than idiopathic / heritable or drug-associated type; or
4.2 Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease; or
4.3 Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures; and
5 Both:
5.1 Ambrisentan is to be used as PAH monotherapy; and
5.2 Any of the following:
5.2.1 Patient has experienced intolerable side effects with both sildenafil and bosentan; or
5.2.2 Patient has an absolute contraindication to sildenafil and an absolute or relative contraindication to bosentan (e.g. due to current use of a combined oral contraceptive or liver disease); or
5.2.3 Patient is a child with idiopathic PAH or PAH secondary to congenital heart disease.

Initiation – PAH dual therapy
Respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist
Limited to 6 months treatment
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 2003) clinical classifications; and
3 PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV; and
4 Any of the following:
4.1 All of the following:
4.1.1 PAH has been confirmed by right heart catheterisation; and
4.1.2 A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair); and
4.1.3 A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg; and
4.1.4 Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm^{-5}); and
4.1.5 Any of the following:
4.1.5.1 PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH ~~(see note below for link to these guidelines) †~~; or
4.1.5.2 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**; or
4.1.5.3 Patient has PAH other than idiopathic / heritable or drug-associated type; or
4.2 Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease; or
4.3 Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures; and
5 Both:
5.1 Ambrisentan is to be used as PAH dual therapy; and
5.2 Any of the following:
5.2.1 Patient has tried bosentan (either as PAH monotherapy, or PAH dual therapy with sildenafil) for at least three months and has not experienced an acceptable response to treatment according to a validated risk stratification tool**; or
5.2.2 Patient has experienced intolerable side effects on bosentan; or
5.2.3 Patient has an absolute or relative contraindication to bosentan (e.g. due to current use of a combined oral contraceptive or liver disease); or

continued...

	Price (ex man. Excl. GST) $	Per	Brand or Generic Manufacturer

Changes to Section H Part II – effective 1 January 2026 (continued)

continued...

5.2.4 Patient is presenting in NYHA/WHO functional class III or IV, and would benefit from initial dual therapy in the opinion of the treating clinician and has an absolute or relative contraindication to bosentan (eg. due to current liver disease or use of a combined oral contraceptive).

Initiation – PAH triple therapy
Respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist
Limited to 6 months treatment
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 2003) clinical classifications; and
3 PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV; and
4 Any of the following:
  4.1 All of the following:
    4.1.1 PAH has been confirmed by right heart catheterisation; and
    4.1.2 A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair); and
    4.1.3 A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg; and
    4.1.4 Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm^{-5}); and
    4.1.5 Any of the following:
      4.1.5.1 PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH ~~(see note below for link to these guidelines) †~~; or
      4.1.5.2 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**; or
      4.1.5.3 Patient has PAH other than idiopathic / heritable or drug-associated type; or
  4.2 Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease; or
  4.3 Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures; and
5 Both:
  5.1 Ambrisentan is to be used as PAH triple therapy; and
  5.2 Any of the following:
    5.2.1 Patient is on the lung transplant list; or
    5.2.2 Both:
      5.2.2.1 Patient is presenting in NYHA/WHO functional class IV; and
      5.2.2.2 Patient has an absolute or relative contraindication to bosentan (e.g. due to current use of a combined oral contraceptive or liver disease); or
    5.2.3 Both:
      5.2.3.1 Patient has tried PAH dual therapy for at least three months and remains in an unacceptable risk category according to a validated risk stratification tool**; and
      5.2.3.2 Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario.

Continuation
Respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist
Re-assessment required after 2 years
The patient is continuing to derive benefit from ambrisentan treatment according to a validated PAH risk stratification tool**.
Notes: ~~† The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the diagnosis and treatment of pulmonary hypertension PAH~~
** the requirement to use a validated risk stratification tool to determine insufficient response applies to adults. Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

➔ Restriction
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	Price (ex man. Excl. GST) $	Per	Brand or Generic Manufacturer

Changes to Section H Part II – effective 1 January 2026 (continued)

57 BOSENTAN (amended restriction criteria)

➔Tab 62.5 mg – **5% DV Jan-25 to 2027**	100.00	60	**Bosentan Dr Reddy's**
➔Tab 125 mg – **5% DV Jan-25 to 2027**	100.00	60	**Bosentan Dr Reddy's**

Restricted
Initiation – PAH monotherapy
Respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist
Limited to 6 months treatment
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 2003) clinical classifications; and
3 PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV; and
4 Any of the following:
  4.1 All of the following:
    4.1.1 PAH has been confirmed by right heart catheterisation; and
    4.1.2 A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair); and
    4.1.3 A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg; and
    4.1.4 Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm^{-5}); and
    4.1.5 Any of the following:
      4.1.5.1 PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH ~~(see note below for link to these guidelines) †~~; or
      4.1.5.2 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**; or
      4.1.5.3 Patient has PAH other than idiopathic / heritable or drug-associated type; or
  4.2 Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease; or
  4.3 Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures; and
5 Both:
  5.1 Bosentan is to be used as PAH monotherapy; and
  5.2 Any of the following:
    5.2.1 Patient has experienced intolerable side effects on sildenafil; or
    5.2.2 Patient has an absolute contraindication to sildenafil; or
    5.2.3 Patient is a child with idiopathic PAH or PAH secondary to congenital heart disease.

Initiation – PAH dual therapy
Respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist
Limited to 6 months treatment
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 2003) clinical classifications; and
3 PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV; and
4 Any of the following:
  4.1 All of the following:
    4.1.1 PAH has been confirmed by right heart catheterisation; and
    4.1.2 A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair); and
    4.1.3 A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg; and
    4.1.4 Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm^{-5}); and

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	Price (ex man. Excl. GST) $	Per	Brand or Generic Manufacturer

Changes to Section H Part II – effective 1 January 2026 (continued)

continued...

4.1.5 Any of the following:
4.1.5.1 PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH ~~(see note below for link to these guidelines) †~~; or
4.1.5.2 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**; or
4.1.5.3 Patient has PAH other than idiopathic / heritable or drug-associated type; or
4.2 Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease; or
4.3 Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures; and
5 Both:
5.1 Bosentan is to be used as part of PAH dual therapy; and
5.2 Either:
5.2.1 Patient has tried a PAH monotherapy (sildenafil) for at least three months and has experienced an inadequate therapeutic response to treatment according to a validated risk stratification tool**; or
5.2.2 Patient is presenting in NYHA/WHO functional class III or IV, and in the opinion of the treating clinician would likely benefit from initial dual therapy.

Initiation – PAH triple therapy
Respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist
Limited to 6 months treatment
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 2003) clinical classifications; and
3 PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV; and
4 Any of the following:
4.1 All of the following:
4.1.1 PAH has been confirmed by right heart catheterisation; and
4.1.2 A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair); and
4.1.3 A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg; and
4.1.4 Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm^{-5}); and
4.1.5 Any of the following:
4.1.5.1 PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH ~~(see note below for link to these guidelines) †~~; or
4.1.5.2 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**; or
4.1.5.3 Patient has PAH other than idiopathic / heritable or drug-associated type; or
4.2 Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease; or
4.3 Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures; and
5 Both:
5.1 Bosentan is to be used as part of PAH triple therapy; and
5.2 Any of the following:
5.2.1 Patient is on the lung transplant list; or
5.2.2 Patient is presenting in NYHA/WHO functional class IV; or
5.2.3 Both:

continued...

➔ Restriction
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Changes to Section H Part II – effective 1 January 2026 (continued)

continued...

5.2.3.1 Patient has tried PAH dual therapy for at least three months and has not experienced an acceptable response to treatment according to a validated risk stratification tool**; and

5.2.3.2 Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario.

Continuation

Respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist

Re-assessment required after 2 years

Patient is continuing to derive benefit from bosentan treatment according to a validated PAH risk stratification tool**.

Notes: ~~† The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the diagnosis and treatment of pulmonary hypertension PAH~~

** the requirement to use a validated risk stratification tool to determine insufficient response applies to adults. Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

60 SILDENAFIL (amended restriction criteria – affected criteria shown only)

➔ Tab 25 mg – **5% DV Dec-24 to 2027**	0.72	4	**Vedafil**
➔ Tab 50 mg – **5% DV Dec-24 to 2027**	1.45	4	**Vedafil**
➔ Tab 100 mg – **5% DV Dec-24 to 2027**	11.22	12	**Vedafil**

➔ Inj 0.8 mg per ml, 12.5 ml vial

Restricted

Initiation – tablets Pulmonary arterial hypertension

Respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist

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 2003) clinical classifications; and
3 PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV; and
4 Any of the following:
  4.1 All of the following:
    4.1.1 PAH is confirmed by right heart catheterisation; and
    4.1.2 A mean pulmonary artery pressure (PAPm) of greater than 20 mmHg; and
    4.1.3 A pulmonary capillary wedge pressure (PCWP) that is less than or equal to 15 mmHg; and
    4.1.4 Pulmonary vascular resistance (PVR) of at least 2 Wood Units or at least 160 International Units (dyn s cm^{-5}); and
    4.1.5 Any of the following:
      4.1.5.1 PAH is non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH ~~(see note below for link to these guidelines) †~~; or
      4.1.5.2 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**; or
      4.1.5.3 Patient has PAH other than idiopathic / heritable or drug-associated type; or
  4.2 Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease; or
  4.3 Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures.

Notes: ~~† The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the diagnosis and treatment of pulmonary hypertension PAH~~

** the requirement to use a validated risk stratification tool to determine insufficient response applies to adults. Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

	Price (ex man. Excl. GST) $	Per	Brand or Generic Manufacturer

Changes to Section H Part II – effective 1 January 2026 (continued)

61 EPOPROSTENOL (amended restriction criteria)

➔Inj 500 mcg vial	36.61	1	Veletri
➔Inj 1.5 mg vial	73.21	1	Veletri

Restricted
Initiation – PAH dual therapy
Respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist
Limited to 6 months treatment
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 2003) clinical classifications; and
3 PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class III or IV; and
4 Any of the following:
  4.1 All of the following:
    4.1.1 PAH has been confirmed by right heart catheterisation; and
    4.1.2 A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair); and
    4.1.3 A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg; and
    4.1.4 A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm^{-5}); and
    4.1.5 Any of the following:
      4.1.5.1 PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH ~~(see note below for link to these guidelines) †~~; or
      4.1.5.2 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**; or
      4.1.5.3 Patient has PAH other than idiopathic / heritable or drug-associated type; or
  4.2 Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease; or
  4.3 Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures; and
5 All of the following:
  5.1 Epoprostenol is to be used as part of PAH dual therapy with either sildenafil or an endothelin receptor antagonist; and
  5.2 Patient is presenting in NYHA/WHO functional class IV; and
  5.3 Patient has tried a PAH monotherapy for at least three months and remains in an unacceptable risk category according to a validated risk stratification tool.

Initiation – PAH triple therapy
Respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist
Limited to 6 months treatment
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 2003) clinical classifications; and
3 PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class III or IV; and
4 Any of the following:
  4.1 All of the following:
    4.1.1 PAH has been confirmed by right heart catheterisation; and
    4.1.2 A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair); and
    4.1.3 A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg; and
    4.1.4 A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm^{-5}); and

continued...

Changes to Section H Part II – effective 1 January 2026 (continued)

continued...

4.1.5 Any of the following:
4.1.5.1 PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH ~~(see note below for link to these guidelines) †~~; or
4.1.5.2 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**; or
4.1.5.3 Patient has PAH other than idiopathic / heritable or drug-associated type; or
4.2 Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease; or
4.3 Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures; and
5 Both:
5.1 Epoprostenol is to be used as PAH triple therapy; and
5.2 Any of the following:
5.2.1 Patient is on the lung transplant list; or
5.2.2 Patient is presenting in NYHA/WHO functional class IV; or
5.2.3 Both:
5.2.3.1 Patient has tried PAH dual therapy for at least three months and has not experienced an acceptable response to treatment according to a validated risk stratification tool; and
5.2.3.2 Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario.

Continuation
Respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist
Re-assessment required after 2 years
Patient is continuing to derive benefit from epoprostenol treatment according to a validated PAH risk stratification tool.
Notes: ~~† The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the diagnosis and treatment of pulmonary hypertension PAH~~
** the requirement to use a validated risk stratification tool to determine insufficient response applies to adults. Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

63 ILOPROST (amended restriction criteria)
➔ Nebuliser soln 10 mcg per ml, 2 ml
– **5% DV Dec-25 to 2028**.....166.53 30 **Vebulis**

Restricted
Initiation – PAH monotherapy
Respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist
Limited to 6 months treatment
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 2003) clinical classifications; and
3 PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV; and
4 Any of the following:
4.1 All of the following:
4.1.1 PAH has been confirmed by right heart catheterisation; and
4.1.2 A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair); and
4.1.3 A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg; and
4.1.4 A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm^{-5}); and

continued...

Changes to Section H Part II – effective 1 January 2026 (continued)

continued...

4.1.5 Any of the following:
4.1.5.1 PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH ~~(see note below for link to these guidelines) †~~; or
4.1.5.2 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**; or
4.1.5.3 Patient has PAH other than idiopathic / heritable or drug-associated type; or
4.2 Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease; or
4.3 Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures; and
5 Both:
5.1 Iloprost is to be used as PAH monotherapy; and
5.2 Either:
5.2.1 Patient has experienced intolerable side effects on sildenafil and both the funded endothelin receptor antagonists (i.e. both bosentan and ambrisentan); or
5.2.2 Patient has an absolute contraindication to sildenafil and an absolute or relative contraindication to endothelin receptor antagonists.

Initiation – PAH dual therapy
Respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist
Limited to 6 months treatment
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 2003) clinical classifications; and
3 PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV; and
4 Any of the following:
4.1 All of the following:
4.1.1 PAH has been confirmed by right heart catheterisation; and
4.1.2 A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair); and
4.1.3 A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg; and
4.1.4 A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm^{-5}); and
4.1.5 Any of the following:
4.1.5.1 PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH ~~(see note below for link to these guidelines) †~~; or
4.1.5.2 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**; or
4.1.5.3 Patient has PAH other than idiopathic / heritable or drug-associated type; or
4.2 Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease; or
4.3 Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures; and
5 All of the following:
5.1 Iloprost is to be used as PAH dual therapy with either sildenafil or an endothelin receptor antagonist; and
5.2 Either:
5.2.1 Patient has an absolute contraindication to or has experienced intolerable side effects on sildenafil; or
5.2.2 Patient has an absolute or relative contraindication to or experienced intolerable side effects with a funded endothelin receptor antagonist; and
5.3 Either:

continued...

	Price (ex man. Excl. GST) $	Per	Brand or Generic Manufacturer

Changes to Section H Part II – effective 1 January 2026 (continued)

continued...

5.3.1 Patient has tried a PAH monotherapy for at least three months and remains in an unacceptable risk category according to a validated risk stratification tool**; or

5.3.2 Patient is presenting in NYHA/WHO functional class III or IV, and in the opinion of the treating clinician would benefit from initial dual therapy.

Initiation – PAH triple therapy

Respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist

Limited to 6 months treatment

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 2003) clinical classifications; and

3 PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV; and

4 Any of the following:

4.1 All of the following:

4.1.1 PAH has been confirmed by right heart catheterisation; and

4.1.2 A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair); and

4.1.3 A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg; and

4.1.4 A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm^{-5}); and

4.1.5 Any of the following:

4.1.5.1 PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH ~~(see note below for link to these guidelines) †~~; or

4.1.5.2 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**; or

4.1.5.3 Patient has PAH other than idiopathic / heritable or drug-associated type; or

4.2 Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease; or

4.3 Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures; and

5 Both:

5.1 Iloprost is to be used as PAH triple therapy; and

5.2 Any of the following:

5.2.1 Patient is on the lung transplant list; or

5.2.2 Patient is presenting in NYHA/WHO functional class IV; or

5.2.3 Both:

5.2.3.1 Patient has tried PAH dual therapy for at least three months and has not experienced an acceptable response to treatment according to a validated risk stratification tool**; and

5.2.3.2 Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario.

Continuation

Respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist

Re-assessment required after 2 years

Patient is continuing to derive benefit from iloprost treatment according to a validated PAH risk stratification tool.

Notes: ~~† The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the diagnosis and treatment of pulmonary hypertension PAH~~

** the requirement to use a validated risk stratification tool to determine insufficient response applies to adults. Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

		Price (ex man. Excl. GST) $	Per	Brand or Generic Manufacturer

Changes to Section H Part II – effective 1 January 2026 (continued)

DERMATOLOGICALS

67 DIMETHICONE (↑ price and addition of PSS)
Lotn 4% – **5% DV Jun-26 to 2028** ..... 4.60 200 ml **healthE Dimethicone 4% Lotion**

68 DIMETHICONE (brand change and addition of PSS)
Crm 5% pump bottle – **5% DV Jun-26 to 2028** ..... 4.14 460 g **HydraLock**
Note – healthE Dimethicone 5% crm 5% pump bottle, 460 g to be delisted from 1 June 2026.

68 DIMETHICONE (↑ price and addition of PSS)
Crm 5% tube – **5% DV Jun-26 to 2028** ..... 1.52 100 g **healthE Dimethicone 5%**

GENITO-URINARY SYSTEM

75 LEVONORGESTREL (brand change and addition of PSS)
Tab 1.5 mg – **5% DV Jun-26 to 2028** ..... 1.31 1 **Levonorgestrel-1 (Lupin)**
Note – Levonorgestrel BNM tab 1.5 mg to be delisted from 1 June 2026.

INFECTIONS

96 METHENAMINE (HEXAMINE) HIPPURATE (new listing)
Tab 1 g ..... 19.95 100 Hiprex
Note – this is a new Pharmacode listing, 209538.

108 ACICLOVIR (new listing)
Inj 250 mg vial ..... 13.75 5 Aciclovir Injection DBL

109 EMTRICITABINE WITH TENOFOVIR DISOPROXIL (new listing)
➔ Tab 200 mg with tenofovir disoproxil 245 mg (300 mg as a fumarate) ..... 13.45 30 Tenofovir Disoproxil Emtricitabine Mylan

MUSCULOSKELETAL SYSTEM

116 TERIPARATIDE (↑ price)
➔ Inj 250 mcg per ml, 2.4 ml ..... 200.27 1 Teriparatide - Teva

117 COLCHICINE (↑ price)
Tab 500 mcg ..... 6.30 100 Colgout

119 KETOPROFEN (delisting)
Cap long-acting 200 mg ..... 12.07 28 Oruvail SR
Note – Oruvail SR cap long-acting 200 mg to be delisted from 1 October 2026.

NERVOUS SYSTEM

122 ROPINIROLE HYDROCHLORIDE (↑ price)
Tab 0.25 mg ..... 8.83 84 Ropin
Tab 1 mg ..... 10.09 84 Ropin
Tab 2 mg ..... 12.29 84 Ropin
Tab 5 mg ..... 25.94 84 Ropin

	Price (ex man. Excl. GST) $	Per	Brand or Generic Manufacturer

Changes to Section H Part II – effective 1 January 2026 (continued)

133 VIGABATRIN (delisting)
➔ Powder for oral soln 500 mg per sachet ..... 71.58 60 Sabril
Note – Sabril powder for oral soln 500 mg per sachet to be delisted from 1 May 2026.

137 ARIPIPRAZOLE (new Pharmacode listing)
➔ Inj 300 mg vial ..... 273.56 1 Abilify Maintena
➔ Inj 400 mg vial ..... 341.96 1 Abilify Maintena
Note – these are new Pharmacode listings, 2717271 and 2717298 respectively. Pharmacodes 2680394 and 2680408 to be delisted from 1 July 2026.

141 GLATIRAMER ACETATE (↑ price)
Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.
➔ Inj 40 mg prefilled syringe ..... 1,500.00 12 Copaxone

149 VARENICLINE (brand change and addition of PSS)
➔ Tab 0.5 mg × 11 and 1 mg × 42 – **5% DV Jun-26 to 2028** ... 15.99 53 **Pharmacor Varenicline**
➔ Tab 1 mg – **5% DV Jun-26 to 2028** ..... 10.99 56 **Pharmacor Varenicline**
Note – Champix tab 0.5 mg × 11 and 1 mg × 42 and tab 1 mg to be delisted from 1 June 2026.

ONCOLOGY AGENTS AND IMMUNOSUPPRESSANTS

236 SECUKINUMAB (new Pharmacode listing)
➔ Inj 150 mg per ml, 1 ml prefilled syringe ..... 1,599.00 2 Cosentyx
Note – this is a new Pharmacode listing, 2719398. Pharmacode 2554712 delisted 1 January 2026.

RESPIRATORY SYSTEM AND ALLERGIES

268 LORATADINE (new listing and addition of PSS)
Tab 10 mg – **5% DV Jun-26 to 2028** ..... 1.59 100 **Loratadine Noumed**

268 LORATADINE (↑ price and delisting)
Tab 10 mg ..... 6.02 100 Lorafix
Note – Lorafix tab 10 mg to be delisted from 1 June 2026.

SENSORY ORGANS

281 SODIUM HYALURONATE [HYALURONIC ACID] (delisted)
Inj 14 mg per ml, 0.85 ml syringe ..... 50.00 1 Healon GV
Note – Healon GV inj 14 mg per ml, 0.85 ml syringe delisted 1 January 2026.

283 CARMELLOSE SODIUM ~~WITH PECTIN AND GELATINE~~ (amended chemical name)
Eye drops 0.5%
Eye drops 0.5%, single dose
Eye drops 1%
Eye drops 1%, single dose

VARIOUS

289 PATENT BLUE V (↑ price)
Inj 2.5%, 5 ml prefilled syringe ..... 435.00 5 InterPharma

		Price (ex man. Excl. GST) $	Per	Brand or Generic Manufacturer

Changes to Section H Part II – effective 1 January 2026 (continued)

289	SODIUM CHLORIDE (↑ price)			
	Irrigation soln 0.9%, 30 ml ampoule	13.25	20	InterPharma
	Irrigation soln 0.9%, 250 ml bottle	24.60	12	Fresenius Kabi
290	WATER (↑ price)			
	Irrigation soln, 250 ml bottle	26.40	12	Fresenius Kabi

➔ Restriction

(Brand) indicates a brand example only. It is not a contracted product.

Index
Pharmaceuticals and brands

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