PHARMAC
TE PĀTAKA WHAIORANGA

Pharmaceutical Management Agency
New Zealand
Pharmaceutical Schedule

Update

March 2026

Contents

Summary of Pharmac decisions
EFFECTIVE 1 MARCH 2026

New listings (pages 20-21)

- Tranexamic acid (Tranexamic-AFT) inj 100 mg per ml, 10 ml ampoule – subsidy by endorsement, up to 5 inj available on a PSO and only on a PSO
- Ticagrelor (Ticagrelor Sandoz S29) tab 90 mg – Special Authority – Retail pharmacy, s29 and wastage claimable
- Glucose [Dextrose] inj 5%, 100 ml bag (Fresenius Kabi) – up to 50 inj available on PSO and inj 10%, 500 ml bag (Baxter Glucose 10%) – up to 18 inj available on a PSO – subsidy by endorsement and only on PSO
- Furosemide (Furosemide-AFT) inj 10 mg per ml, 2 ml ampoule – up to 10 inj available on a PSO
- Teriparatide (Forteo) inj 250 mcg per ml, 2.4ml – Special Authority – Retail pharmacy and s29
- Ketamine (Ketalar) inj 100 mg per ml, 2 ml vial – subsidy by endorsement and up to 5 inj available on a PSO
- Methoxyflurane (Penthrox) – subsidy by endorsement and only on a PSO
  - Soln for inhalation 999.9 mg per g, 3 ml bottle with inhaler device and activated carbon chamber, 1 OP – up to 2 packs available on PSO
  - Soln for inhalation 999.9 mg per g, 3 ml bottle, 10 pack – up to 10 bottles available on a PSO
- Droperidol (Droperidol Medsurge) inj 2.5 mg per ml, 1 ml ampoule – subsidy by endorsement, up to 10 inj available on a PSO and only on a PSO
- Olanzapine (Olanzapina Mylan Pharma and Olanzapina Mylan) tab orodispersible 10 mg – Safety medicine, s29 and wastage
- Pharmacy Services (BSF Lyrica) – brand switch fee, may only be claimed once per patient
- Diabetic oral feed 1kcal/ml (Nutren Diabetes) liquid (vanilla), 200 ml bottle, 4 bottle pack – Special Authority– Hospital pharmacy [HP3]
- Oral elemental feed 1kcal/ml (Vivonex TEN) powder (unflavoured), 80 g sachet – Special Authority – Hospital pharmacy [HP3]
- Influenza vaccine (Influvac Tetra (2026 formulation)) inj 60 mcg in 0.5 ml syringe (quadrivalent vaccine) – maximum of 1 inj per prescription, only on a prescription, no patient co-payment payable and access criteria apply

Changes to restrictions (pages 22-47)

- Enoxaparin sodium (Clexane) syringes – addition of subsidy by endorsement that can be waived by Special Authority
- Enoxaparin sodium (Clexane) inj 100 mg in 1 ml syringe – up to 2 inj available on a PSO

Summary of Pharmac decisions – effective 1 March 2026 (continued)

- Filgrastim (Nivestim) inj 300 mcg per 0.5 ml prefilled syringe and inj 480 mcg per 0.5 ml prefilled syringe – amend Special Authority criteria
- Pegfilgrastim (Ziextenzo) inj 6 mg per 0.6 ml syringe – amend Special Authority criteria
- Losartan potassium with hydrochlorothiazide (Losartan & Hydrochlorothiazide (Ipca)) tab 50mg with hydrochlorothiazide 12.5 mg – amended brand name
- Furosemide (Furosemide-Baxter and Furosemide-AFT) inj 10 mg per ml, 2 ml ampoule – amended quantity on a PSO
- Oestradiol (Estradiol TDP Mylan and Estradot) patch 25 mcg, 50 mcg, 75 mcg and 100 mcg per day – removal of brand switch fee
- Efavirenz (Efavirenz Milpharm) tab 600 mg – addition of stat dispensing
- Etravirine (Intelence) tab 200 mg – addition of stat dispensing
- Nevirapine tab 200mg (Nevirapine Viatris) and oral suspension 10 mg per ml, 240 ml OP (Viramune Suspension) – addition of stat dispensing
- Abacavir sulphate (Ziagen) tab 300 mg – addition of stat dispensing
- Abacavir sulphate with lamivudine (Abacavir/Lamivudine Viatris) tab 600 mg with lamivudine 300 mg – addition of stat dispensing
- Efavirenz with emtricitabine and tenofovir disoproxil tab 600 mg with emtricitabine 200 mg and tenofovir disoproxil 245 mg (300 mg as a fumarate) (TEEVIR) and tab 600 mg with emtricitabine 200 mg and tenofovir disoproxil 245 mg (300 mg as a maleate) (Viatris) – addition of stat dispensing
- Emtricitabine (Emtriva) cap 200 mg – addition of stat dispensing
- Lamivudine tab 150 mg (Lamivudine Viatris) and oral liq 10 mg per ml, 240 ml OP (3TC) – addition of stat dispensing
- Zidovudine (Retrovir) cap 100 mg and oral liq 10 mg per ml, 200 ml OP – addition of stat dispensing and amended chemical name
- Zidovudine with lamivudine (Lamivudine/Zidovudine Viatris) tab 300 mg with lamivudine 150 mg – addition of stat dispensing
- Atazanavir sulphate (Atazanavir Viatris) tab 150 mg and 200 mg – addition of stat dispensing
- Darunavir (Darunavir Viatris) tab 400 mg and 600 mg – addition of stat dispensing
- Lopinavir with ritonavir (Lopinavir/Ritonavir Mylan) tab 200 mg with ritonavir 50 mg – addition of stat dispensing
- Ritonavir (Norvir) tab 100 mg – addition of stat dispensing
- Dolutegravir (Tivicay) tab 50 mg – addition of stat dispensing
- Dolutegravir with lamivudine (Dovato) tab 50 mg with lamivudine 300 mg – addition of stat dispensing

- Raltegravir potassium tab 400mg (Isentress) and tab 600 mg (Isentress HD) – addition of stat dispensing
- Pregabalin (Lyrica and Pregabalin Pfizer) cap 25 mg, 75 mg, 150 mg and 300 mg – addition of brand switch fee
- Pegaspargase (Oncaspar LYO) inj 750 iu per ml, 5 ml vial – amended Special Authority criteria
- Etanercept (Enbrel) inj 25 mg, 25 mg autoinjector, 50 mg autoinjector and 50 mg prefilled syringe – amended Special Authority criteria
- Infliximab inj 100 mg (Remicade) and inj 1 mg for ECP (Baxter) – amended Special Authority criteria
- Palivizumab (Synagis) inj 100 mg per ml, 1 ml vial – amended Special Authority criteria
- Rituximab (Mabthera) inj 100 mg per 10 ml vial and inj 500 mg per 50 ml vial (Mabthera) and inj 1 mg for ECP (Baxter (Mabthera)) – amended Special Authority criteria
- Rituximab (Riximyo) inj 100 mg per 10 ml vial and inj 500 mg per 50 ml vial (Riximyo) and inj 1 mg for ECP (Baxter (Riximyo)) – amended Special Authority criteria
- Secukinumab (Cosentyx) inj 150 mg per ml, 1 ml prefilled syringe – amended Special Authority criteria

Increased subsidy (pages 48-49)

- Heparin sodium (Pfizer) inj 1,000 iu per ml, 5 ml ampoule
- Adrenaline inj 1 in 1,000, 1 ml ampoule (DBL Adrenaline) and inj 1 in 10,000, 10 ml ampoule (Hospira)
- Ethinyloestradiol with norethisterone tab 35 mcg with norethisterone 1 mg and 7 inert tab (Brevinor 1/28) and tab 35 mcg with norethisterone 500 mcg and 7 inert tab (Norimin)
- Norethisterone (Noriday 28) tab 350 mcg
- Testosterone cipionate (Depo-Testosterone) inj 100 mg per ml, 10 ml vial
- Medroxyprogesterone acetate (Provera) tab 2.5 mg, 5 mg and 10 mg
- Medroxyprogesterone acetate (Provera HD) tab 100 mg
- Gentamicin sulphate (DBL Gentamicin) inj 10 mg per ml, 1 ml ampoule
- Midazolam (Midazolam-Pfizer) inj 1 mg per ml, 5 ml plastic ampoule and inj 5 mg per ml, 3 ml plastic ampoule

Decreased subsidy (pages 48-49)

- Carvedilol (Carvedilol Sandoz) tab 6.25 mg, 12.5 mg and 25 mg
- Haloperidol (Serenace) inj 5 mg per ml, 1 ml ampoule
- Daunorubicin inj 18.7 mg vial (Pfizer) and inj 18.7 mg for ECP (Baxter)

Tender News

Sole Subsidised Supply (SSS) or Principal Supply Status (PSS) changes – effective 1 April 2026

Chemical Name	Presentation; Pack size	PSS/SSS	PSS/SSS brand (and supplier)
Ethinyloestradiol with levonorgestrel	Tab 20 mcg with levonorgestrel 100 mcg and 7 inert tabs; 84 tab	PSS	Lo-Oralcon 20 ED (Maple)
Ethinyloestradiol with levonorgestrel	Tab 30 mcg with levonorgestrel 150 mcg and 7 inert tabs; 84 tab	PSS	Oralcon 30 ED (Maple)
Lidocaine [lignocaine] hydrochloride	Oral (gel) soln 2%; 200 ml	PSS	Xylocaine Viscous (Aspen)
Metoclopramide hydrochloride	Inj 5 mg per ml, 2 ml ampoule; 10 inj	PSS	Medsurge (Medsurge)
Sertraline	Tab 50 mg; 30 tab	PSS	Setrona (Douglas)
Sertraline	Tab 100 mg; 30 tab	PSS	Setrona (Douglas)

Looking Forward

This section is designed to alert both pharmacists and prescribers to possible future changes to the Pharmaceutical Schedule. It may also assist pharmacists, distributors and wholesalers to manage stock levels.

Decisions for implementation 1 April 2026

- Atezolizumab inj 60 mg per ml, 20 ml vial (Tecentriq) and inj 1 mg for ECP (Baxter) – amended Special Authority criteria
- Bortezomib (Bortezomib Eugia) inj 3.5 mg vial – new listing
- Pembrolizumab inj 25 mg per ml, 4 ml vial (Keytruda) and inj 1 mg for ECP (Baxter) – amended Special Authority criteria

Possible decisions for future implementation 1 April 2026

- Brentuximab vedotin (Adcetris) inj 50 mg vial – amended Special Authority criteria
- Elexacaftor with tezacaftor, ivacaftor and ivacaftor (Trikafta) oral granules elexacaftor 100 mg with tezacaftor 50 mg, ivacaftor 75 mg (28) and ivacaftor 150 mg (28), sachets, 56 OP and oral granules elexacaftor 80 mg with tezacaftor 40 mg, ivacaftor 60 mg (28) and ivacaftor 59.5mg (28), sachets, 56 OP – new listing
- Elexacaftor with tezacaftor, ivacaftor and ivacaftor (Trikafta) tab and oral granules – amended Special Authority criteria
- Ivacaftor (Kalydeco) oral granules 13.4 mg, sachet and oral granules 25 mg, sachet – new listing
- Ivacaftor (Kalydeco) Tab and oral granules – amended Special Authority criteria

Sole Subsidised Supply (SSS) or Principal Supply Status (PSS) Products – Cumulative to March 2026

Generic Name	Presentation	Brand Name	Expiry Date*
Abacavir sulphate with lamivudine	Tab 600 mg with lamivudine 300 mg	Abacavir/Lamivudine Viatris	2028
Acarbose	Tab 50 mg & 100 mg	Accarb	2027
Acetazolamide	Tab 250 mg	Medsurge	2027
Acetylcysteine	Inj 200 mg per ml, 10 ml ampoule	DBL Acetylcysteine	2027
Aciclovir	Tab dispersible 200 mg, 400 mg & 800 mg Eye oint 3%, 4.5 g OP	Lovir ViruPOS	2028 2027
Acitretin	Cap 10 mg and 25 mg	Novatretin	2026
Adalimumab (Amgevita)	Inj 20 mg per 0.4 ml prefilled syringe, inj 40 mg per 0.8 ml prefilled syringe & inj 40 mg per 0.8 ml prefilled pen	Amgevita	31/07/2026
Adrenaline	Inj 0.15 mg per 0.3 ml autoinjector, 1 OP Inj 0.3 mg per 0.3 ml autoinjector, 1 OP	EpiPen Jr EpiPen	2028
Alendronate sodium	Tab 70 mg	Fosamax	2026
Alendronate sodium with colecalciferol	Tab 70 mg with colecalciferol 5,600 iu	Fosamax Plus	2026
Allopurinol	Tab 100 mg and 300 mg	Ipca-Allopurinol	2026
Ambrisentan	Tab 5 mg & 10 mg	Ambrisentan Viatris	2026
Amiodarone hydrochloride	Tab 100 mg & 200 mg Inj 50 mg per ml, 3 ml ampoule	Aratac Max Health	2028
Amisulpride	Tab 100 mg, 200 mg & 400 mg	Sulprix	2027
Amitriptyline	Tab 10 mg, 25 mg and 50 mg	Arrow-Amitriptyline	2026
Amlodipine	Tab 2.5 mg, 5 mg and 10 mg	Vasorex	2026
Amorolfine	Nail soln 5%, 5 ml OP	MycoNail	2026
Amoxicillin	Cap 250 mg Grans for oral liq 125 mg per 5 ml Grans for oral liq 250 mg per 5 ml	Miro-Amoxicillin Alphamox 125 Alphamox 250	2028 2026
Amoxicillin with clavulanic acid	Grans for oral liq amoxicillin 50 mg with clavulanic acid 12.5 mg per ml Grans for oral liq amoxicillin 25 mg with clavulanic acid 6.25 mg per ml Tab 500 mg with clavulanic acid 125 mg	Amoxiclav Devatis Forte Augmentin Curam Duo 500/125	2027 2026
Anastrazole	Tab 1 mg	Anatrole	2026
Aprepitant	Cap 2 x 80 mg and 1 x 125 mg	Emend	2027
Aqueous cream	Crm, 500 g	Evara	2027
Ascorbic acid	**Tab 100 mg**	**Cvite**	**2028**
Aspirin	Tab 100 mg Tab dispersible 300 mg	Ethics Aspirin EC Ethics Aspirin	2026
Atazanavir sulphate	Cap 150 mg & 200 mg	Atazanavir Viatris	2028

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Sole Subsidised Supply (SSS) or Principal Supply Status (PSS) Products – Cumulative to March 2026

Generic Name	Presentation	Brand Name	Expiry Date*
Atenolol	Tab 50 mg Tab 100 mg	Viatris Atenolol Viatris	2027
Atomoxetine	Cap 10 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg and 100 mg	APO-Atomoxetine	2026
Atorvastatin	Tab 10 mg, 20 mg, 40 mg & 80 mg	Lorstat	2027
Atropine sulphate	Inj 600 mcg per ml, 1 ml ampoule Eye drops 1%, 15 ml OP	Martindale Atropt	2027 2026
Azathioprine	Tab 25 mg & 50 mg	Azamun	2028
Azithromycin	Tab 500 mg	Zithromax	2027
Bacillus calmette-guerin vaccine	Inj Mycobacterium bovis BCG (Bacillus Calmette-Guerin), Danish strain 1331, live attenuated, vial with diluent	BCG Vaccine AJV	2027
Baclofen	Inj 2 mg per ml, 5 ml ampoule Tab 10 mg	Baclofen Sintetica Pacifen	2027
Bendroflumethiazide [Bendrofluazide]	Tab 2.5 mg and 5 mg	Arrow-Bendrofluazide	2026
Benzylpenicillin sodium [Penicillin G]	Inj 600 mg (1 million units) vial	Sandoz	2026
Betahistine dihydrochloride	Tab 16 mg	Serc	2026
Betamethasone dipropionate	Crm 0.05%, 15 g OP and 50 g OP Oint 0.05%, 15 g OP and 50 g OP	Diprosone	2026
Betamethasone dipropionate with calcipotriol	Gel 500 mcg with calcipotriol 50 mcg per g, 60 g OP Oint 500 mcg with calcipotriol 50 mcg per g; 30 g OP	Daivobet	2027
Betamethasone valerate	Lotn 0.1% Crm 0.1%, 50 g OP Oint 0.1%, 50 g OP Scalp app 0.1%, 100 ml OP	Betnovate Beta Cream Beta Ointment Beta Scalp	2027
Bezafibrate	Tab 200 mg Tab long-acting 400 mg	Bezalip Bezalip Retard	2027
Bicalutamide	Tab 50 mg	Binarex	2026
Bimatoprost	Eye drops 0.03%, 3 ml OP	Lumigan	2027
Bisacodyl	Suppos 10 mg	Lax-Suppositories	2027
Bisoprolol fumarate	Tab 2.5 mg, 5 mg and 10 mg	Ipca-Bisoprolol (Ipca)	2026
Bosentan	Tab 62.5 mg & 125 mg	Bosentan Dr Reddy's	2027
Brimonidine tartrate	Eye drops 0.2%, 5 ml OP	Arrow-Brimonidine	2027
Brimonidine tartrate with timolol maleate	Eye drops 0.2% with timolol maleate 0.5%, 5 ml OP	Combigan	2027
Brinzolamide	Eye drops 1%, 5 ml OP	Azopt	2027

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Sole Subsidised Supply (SSS) or Principal Supply Status (PSS) Products – Cumulative to March 2026

Generic Name	Presentation	Brand Name	Expiry Date*
Budesonide	Cap modified-release 3 mg Metered aqueous nasal spray, 50 mcg & 100 mcg per dose, 200 dose OP	Budesonide Te Arai SteroClear	2028 2027
Bupropion hydrochloride	Tab modified-release 150 mg	Zyban	2026
Buspirone hydrochloride	Tab 5 mg & 10 mg	Buspirone Viatris	2027
Calamine	Crm, aqueous, BP	healthE Calamine Aqueous	2027
Calcium carbonate	Tab 1.25 g (500 mg elemental)	Calci-Tab 500	2026
Candesartan cilexetil	Tab 4 mg, 8 mg, 16 mg and 32 mg	Candestar	2027
Capecitabine	Tab 150 mg & 500 mg	Capecitabine Viatris	2028
Captopril	Oral liq 5 mg per ml, 100 ml OP	DP-Captopril (Douglas)	2026
Carbimazole	Tab 5 mg	Neo-Mercazole	2028
Cefaclor monohydrate	Cap 250 mg Grans for oral liq 125 mg per 5 ml	Ranbaxy-Cefaclor	2028
Cefazolin	Inj 500 mg, 1 g and 2 g vial	Cefazolin-AFT	2026
Ceftriaxone	Inj 500 mg & 1 g vial	Ceftriaxone-AFT	2028
Celecoxib	Cap 100 mg	Celebrex	2028
Cetirizine hydrochloride	Tab 10mg	Zista	2026
Cetomacrogol	Crm BP, 500 g	Cetomacrogol-AFT	2027
Cetomacrogol with glycerol	Crm 90% with glycerol 10%, 460 g OP & 920 g OP	Evara	2028
Chloramphenicol	**Eye drops 0.5%, 10 ml OP** Eye oint 1%, 5 g OP	**Chlorafast** Devatis	**2028**
Chlortalidone [Chlorthalidone]	Tab 25 mg	Hygroton	2028
Cinacalcet	Tab 30 mg & 60 mg	Cinacalcet Devatis	2027
Ciprofloxacin	Eye drops 0.3%, 5 ml OP Tab 750 mg Tab 250 mg & 500 mg	Ciprofloxacin Teva Ipca-Ciprofloxacin	2027 2026
Clarithromycin	Tab 250 mg & 500 mg	Klacid	2027
Clindamycin	**Inj 150 mg per ml, 4 ml ampoule** Cap 150 mg	**Dalacin C**	**2028** 2026
Clobetasol propionate	Crm & oint 0.05%, 30 g OP Scalp app 0.05%, 30 ml OP	Dermol	2028
Clomipramine hydrochloride	Tab 25 mg	APO Clomipramine	2027
Clonidine	Patch 2.5 mg, 100 mcg per day Patch 5 mg, 200 mcg per day Patch 7.5 mg, 300 mcg per day	Mylan	2026
Clonidine hydrochloride	Tab 25 mcg Tab 150 mcg Inj 150 mcg per ml, 1 ml ampoule	Clonidine Teva Catapres	2028 2027

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Sole Subsidised Supply (SSS) or Principal Supply Status (PSS) Products – Cumulative to March 2026

Generic Name	Presentation	Brand Name	Expiry Date*
Clopidogrel	Tab 75 mg	Arrow-Clopid	2028
Codeine phosphate	Tab 15 mg, 30 mg & 60 mg	Noumed	2028
Colecalciferol	Cap 1.25 mg (50,000 iu)	Vit.D3	2026
Compound electrolytes	Powder for oral soln	Electral	2028
Covid-19 vaccine	Inj 3 mcg SARS-CoV-2 spike protein (mRNA) P.8.1 per 0.3 ml, 0.48 ml multi-dose vial; infant vaccine, yellow cap Inj 10 mcg SARS-CoV-2 spike protein (mRNA) P.8.1 per 0.3 ml, 0.48 ml single-dose vial; paediatric vaccine, light blue cap Inj 30 mcg SARS-CoV-2 spike protein (mRNA) LP.8.1 per 0.3 ml, pre-filled syringe; adult dose	Comirnaty (LP.8.1)	30/09/2027
Crotamiton	Crm 10%, 20 g OP	Itch-Soothe	2027
Cyclizine hydrochloride	Tab 50 mg	Nausicalm	2027
Cyclophosphamide	Tab 50 mg	Cyclonex	2027
Cyproterone acetate	Tab 50 mg & 100 mg	Siterone	2027
Cyproterone acetate with ethinyloestradiol	Tab 2 mg with ethinyloestradiol 35 mcg and 7 inert tablets	Ginet	2026
Dabigatran	Cap 75 mg, 110 mg and 150 mg	Pradaxa	2026
Darunavir	Tab 400 mg and 600 mg	Darunavir Viatris	2026
Dasatinib	Tab 20 mg, 50 mg & 70 mg	Dasatinib-Teva	2027
Desmopressin acetate	Nasal spray 10 mcg per dose, 6 ml OP	Desmopressin-PH&T	2026
Dexamethasone	Tab 0.5 mg & 4 mg	Dexmethsone	2027
Dexamethasone phosphate	**Inj 4 mg per ml, 1 ml & 2 ml ampoule**	**Dexamethasone Medsurge**	**2028**
Diazepam	Tab 2 mg and 5 mg	Arrow-Diazepam	2026
Diclofenac sodium	Tab long-acting 75 mg Eye drops 0.1%, single dose; 10 dose OP & 30 dose OP Tab EC 25 mg & 50 mg	Voltaren SR Diclofenac Devatis Diclofenac Sandoz	2028 2027
Digoxin	Tab 62.5 mcg Tab 250 mcg	Lanoxin PG Lanoxin	2028
Dihydrocodeine tartrate	Tab long-acting 60 mg	DHC Continus	2028
Diltiazem hydrochloride	Cap long-acting 120 mg Cap long-acting 180 mg & 240 mg	Diltazem CD Clinect Cardizem CD	2028 2027
Diphtheria, tetanus and pertussis vaccine	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 prefilled syringe	Boostrix	2027

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Sole Subsidised Supply (SSS) or Principal Supply Status (PSS) Products – Cumulative to March 2026

Generic Name	Presentation	Brand Name	Expiry Date*
Diphtheria, tetanus, pertussis and polio vaccine	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;	Infanrix IPV	2027
Diphtheria, tetanus, pertussis, polio, hepatitis B and haemophilus influenzae type B vaccine	Inj 30IU diphtheria with 40IU tetanus and 25mcg pertussis toxoids, 25mcg pertussis filamentous haemagglutinin, 8mcg pertactin, 80D-AgU polio virus, 10mcg hepatitis B antigen, 10mcg H. influenzae type b with tetanus toxoid 20-40mcg in 0.5ml syringe	Infanrix-hexa	2027
Docusate sodium	Tab 50 mg and 120 mg	Coloxyl	2026
Domperidone	Tab 10 mg	Domperidone Viatris	2028
Donepezil hydrochloride	Tab 5 mg and 10 mg	Ipca-Donepezil	2026
Dorzolamide with timolol	Eye drops 2% with timolol 0.5%, 5 ml OP	Dortimopt	2027
Econazole nitrate	Crm 1%	Pevaryl	2027
Emtricitabine with tenofovir disoproxil	Tab 200 mg with tenofovir disoproxil 245 mg (300 mg as a maleate)	Tenofovir Disproxil Emitractabine Viatris	2028
Emulsifying ointment	Oint BP, 500 g	Emulsifying Ointment ADE	2026
Enalapril maleate	Tab 5 mg, 10 mg and 20 mg	Acetec	2026
Enoxaparin sodium	Inj 20 mg in 0.2 ml syringe Inj 40 mg in 0.4 ml syringe Inj 60 mg in 0.6 ml syringe Inj 80 mg in 0.8 ml syringe Inj 100 mg in 1 ml syringe Inj 120 mg in 0.8 ml syringe Inj 150 mg in 1 ml syringe	Clexane	2027
Entacapone	Tab 200 mg	Entacapone Viatris	2027
Entecavir	Tab 0.5 mg	Entecavir	2026
Eplerenone	Tab 25 mg & 50 mg	Inspra	2027
Erlotinib	Tab 100 mg & 150 mg	Alchemy	2027
Erythromycin (as lactobionate)	Inj 1 g	Erythrocin IV	2028
Escitalopram	Tab 10 mg & 20 mg	Ipca-Escitalopram (Ipca)	2026
Exemestane	Tab 25 mg	Pfizer Exemestane	2026
Ezetimibe	Tab 10 mg	Ezetimibe Sandoz	2026
Febuxostat	Tab 80 mg and 120 mg	Febuxostat (Teva)	2026
Felodipine	Tab long-acting 2.5 mg Tab long-acting 5 mg Tab long-acting 10 mg	Plendil ER Felo 5 ER Felo 10 ER	2027

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Sole Subsidised Supply (SSS) or Principal Supply Status (PSS) Products – Cumulative to March 2026

Generic Name	Presentation	Brand Name	Expiry Date*
Fentanyl	Inj 50 mcg per ml, 2 ml ampoule and 10 ml ampoule Patches 12.5 mcg, 25 mcg, 50 mcg, 75 mcg & 100 mcg per hour	Boucher and Muir Fentanyl Sandoz	2027
Ferrous fumarate	Tab 200 mg (65 mg elemental)	Ferro-tab	2027
Ferrous fumarate with folic acid	Tab 310 mg (100 mg elemental) with folic acid 350 mcg	Ferro-F-Tabs	2027
Ferrous sulfate	Oral liq 30 mg (6 mg elemental) per 1 ml	Ferro-Liquid	2028
Fexofenadine hydrochloride	Tab 120 mg & 180 mg	Fexaclear	2027
Filgrastim	Inj 300 mcg & 480 mcg per 0.5 ml prefilled syringe	Nivestim	2027
Finasteride	Tab 5 mg	Ricit	2026
Flecainide acetate	Tab 50 mg Cap long-acting 100 mg & 200 mg	Flecainide BNM Flecainide Controlled Release Teva	2026
Flucloxacillin	Cap 250 mg & 500 mg Grans for oral liq 25 mg & 50 mg per ml, 100 ml Inj 250 mg vial and 500 mg vial Inj 1 g vial	Staphlex AFT Flucloxin Flucil	2027 2026
Fluconazole	Cap 50 mg, 150 mg & 200 mg	Mylan	2026
Fludrocortisone acetate	Tab 100 mcg	Florinef	2028
Fluorouracil	Crm 5%, 20 g OP	Efudix	2027
Fluoxetine hydrochloride	**Cap 20 mg** **Tab dispersible 20 mg, scored**	**Arrow – Fluoxetine Fluox**	**2028**
Folic acid	Tab 5 mg	Folic Acid Viatris	2027
Fosfomycin	Powder for oral solution, 3 g sachet	UroFos	2027
Furosemide [Frusemide]	Tab 40 mg	IPCA-Frusemide	2027
Gabapentin	Cap 100 mg, 300 mg & 400 mg	Nupentin	2027
Gliclazide	Tab 80 mg	Glizide	2026
Glipizide	Tab 5 mg	Minidiab	2027
Glucose [Dextrose]	Inj 50%, 10 ml ampoule Inj 50%, 90 ml bottle	Biomed	2026
Glycerol	Suppos 2.8/4.0 g	Lax-suppositories Glycerol	2028
Goserelin	Implant 3.6 mg, syringe and 10.8 mg, syringe	Zoladex (AstraZeneca)	2026
Haemophilus influenzae type B vaccine	Inj 10 mcg vial with diluent syringe	Act-HIB	2027
Hepatitis A vaccine	Inj 1440 ELISA units in 1 ml syringe Inj 720 ELISA units in 0.5 ml syringe	Havrix 1440	2027

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Sole Subsidised Supply (SSS) or Principal Supply Status (PSS) Products – Cumulative to March 2026

Generic Name	Presentation	Brand Name	Expiry Date*
Hepatitis B recombinant vaccine	Inj 10 mcg per 0.5 ml prefilled syringe Inj 20 mcg per 1 ml prefilled syringe	Engerix-B	2027
Human papillomavirus (6, 11, 16, 18, 31, 33, 45, 52 and 58) vaccine [HPV]	Inj 270 mcg in 0.5 ml syringe	Gardasil 9	2027
Hydrocortisone	Crm 1%, 500 g Inj 100 mg vial	Noumed Solu-Cortef	2028 2027
Hydrocortisone and paraffin liquid and lanolin	Lotn 1% with paraffin liquid 15.9% and lanolin 0.6%, 250 ml	DP Lotn (HC)	2026
Hydrocortisone with miconazole	Crm 1% with miconazole nitrate 2%, 15 g OP	Micreme H	2027
Hydrogen peroxide	Crm 1%, 15 g OP	Crystaderm	2028
Hydroxocobalamin	Inj 1 mg per ml, 1 ml ampoule	Hydroxocobalamin Panpharma	2027
Hydroxychloroquine sulphate	Tab 200 mg	Ipca-Hydroxychloroquine	2027
Hydroxyurea [hydroxycarbamide]	Cap 500 mg	Devatis	2026
Hyoscine Butylbromide	Tab 10 mg Inj 20 mg, 1 ml	Hyoscine Butylbromide (Adiramedica) Spazmol	2027 2026
Ibuprofen	Oral liq 20 mg per ml Tab long-acting 800 mg Tab 200 mg	Ethics Ibuprofen SR BNM Relieve	2027 2026
Iloprost	Nebuliser soln 10 mcg per ml, 2 ml	Vebulis	2028
Imatinib Mesilate	Cap 100 mg & 400 mg	Imatinib-Rex	2026
Indapamide	Tab 2.5 mg	Dapa-Tabs	2026
Isoniazid	Tab 100 mg	Noumed Isoniazid	2027
Isoniazid with rifampicin	Tab 100 mg with rifampicin 150 mg Tab 150 mg with rifampicin 300 mg	Rifinah	2027
Isosorbide mononitrate	Tab 20 mg Tab long-acting 40 mg Tab long-acting 60 mg	Ismo 20 Ismo 40 Retard Duride	2026
Isotretinoin	Cap 5 mg, 10 mg & 20 mg	Oratane	2027
Ketoconazole	Shampoo 2%, 100 ml OP	Sebizole	2026
Lactulose	Oral liq 10 g per 15 ml	Laevolac	2028
Lamivudine	Tab 100 mg Tab 150 mg	Zetlam Lamivudine Viatris	2026
Lanreotide	Inj 90 mg per 0.5 ml, 0.5 ml syringe Inj 60 mg per 0.5 ml, 0.5 ml syringe Inj 120 mg per 0.5 ml, 0.5 ml syringe	Mytolac	2027

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Sole Subsidised Supply (SSS) or Principal Supply Status (PSS) Products – Cumulative to March 2026

Generic Name	Presentation	Brand Name	Expiry Date*
Lansoprazole	Cap 15 mg & 30 mg	Lanzol Relief	2027
Latanoprost	Eye drops 0.005%, 2.5 ml OP	Teva	2027
Latanoprost with timolol	Eye drops 0.005% with timolol 0.5%, 2.5 ml OP	Arrow - Lattim	2026
Leflunomide	Tab 10 mg & 20 mg	Arava	2026
Lenalidomide	Cap 5 mg, 10 mg, 15 mg & 25 mg	Lenalidomide Viatris	31/01/2028
Letrozole	Tab 2.5 mg	Letrole	2027
Levodopa with carbidopa	Tab 100 mg with carbidopa 25 mg Tab 250 mg with carbidopa 25 mg Tab long-acting 200 mg with carbidopa 50 mg	Sinemet Sinemet CR	2027
Levodopa with carbidopa and entacapone	Tab 50 mg with carbidopa 12.5 mg and entacapone 200 mg Tab 100 mg with carbidopa 25 mg and entacapone 200 mg Tab 150 mg with carbidopa 37.5 mg and entacapone 200 mg Tab 200 mg with carbidopa 50 mg and entacapone 200 mg	Stalevo	2027
Levomepromazine hydrochloride	Inj 25 mg per ml, 1 ml ampoule	Wockhardt	2028
Levonorgestrel	Subdermal implant (2 × 75 mg rods)	Jadelle	2026
Lidocaine [lignocaine]	Gel 2%, 11 ml urethral syringe	Instillagel Lido	2028
Linezolid	Tab 600 mg	Zyvox	2027
Lisinopril	**Tab 5 mg, 10 mg & 20 mg**	**Teva Lisinopril**	**2028**
Lithium carbonate	Tab long-acting 400 mg	Priadel	2027
Loperamide hydrochloride	Cap 2 mg	Diamide Relief	2028
Lopinavir with ritonavir	Tab 200 mg with ritonavir 50 mg	Lopinavir/Rotinavir Mylan	2027
Lorazepam	Tab 1 mg & 2.5 mg	Ativan	2027
Losartan potassium	Tab 12.5 mg, 25 mg, 50 mg and 100 mg	Losartan Actavis	2026
Magnesium sulphate	Inj 2 mmol per ml, 5ml ampoule; 10 inj	Martindale	2026
Measles, mumps and rubella vaccine	Inj, measles virus 1,000 CCID50, mumps virus 5,012 CCID50, Rubella virus 1,000 CCID50; prefilled syringe/ ampoule of diluent 0.5 ml	Priorix	2027
Mebendazole	Tab 100 mg	Vermox	2027
Mebeverine hydrochloride	Tab 135 mg	Colofac	2026
Melatonin	Tab modified-release 2 mg	Vigisom	2027
Meningococcal (groups A, C, Y and W-135) conjugate vaccine	Inj 10 mcg of each meningococcal polysaccharide conjugated to a total of approximately 55 mcg of tetanus toxoid carrier per 0.5 ml vial	MenQuadfi	2027

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Sole Subsidised Supply (SSS) or Principal Supply Status (PSS) Products – Cumulative to March 2026

Generic Name	Presentation	Brand Name	Expiry Date*
Mercaptopurine	Tab 50 mg	Puri-nethol	2028
Metformin hydrochloride	Tab immediate-release 500 mg & 850 mg	Metformin Viatris	2027
Methadone hydrochloride	Oral liq 2 mg per ml, 200 ml Oral liq 5 mg per ml, 200 ml Oral liq 10 mg per ml, 200 ml	Biodone Biodone Forte Biodone Extra Forte	2027
Methotrexate	Inj 7.5 mg, 10 mg, 15 mg, 20 mg, 25 mg & 30 mg prefilled syringe Tab 2.5 mg & 10 mg	Methotrexate Sandoz Trexate	2027
Methylprednisolone aceponate	Crm 0.1%, 15 g OP Oint 0.1%, 15 g OP	Advantan	2026
Metoclopramide hydrochloride	Tab 10 mg	Metoclopramide Actavis 10	2026
Metoprolol succinate	Tab long-acting 23.75 mg, 47.5 mg, 95 mg and 190 mg	Myloc CR (Viatris)	2026
Metoprolol tartrate	Tab 50 mg & 100 mg	IPCA-Metoprolol	2027
Metronidazole	Tab 200 mg & 400 mg	Metronidamed	2026
Miconazole	Oral gel 20 mg per g, 40 g OP	Decozol	2027
Miconazole nitrate	Crm 2%, 15 g OP	Multichem	2026
Midodrine	Tab 2.5 mg & 5 mg	Midodrine Medsurge	2027
Mirtazapine	Tab 30 mg & 45 mg	Noumed	2028
Moclobemide	Tab 150 mg & 300 mg	Aurorix	2027
Modafinil	Tab 100 mg	Modafinil Max Health	2027
Mometasone furoate	Lotn 0.1%, 30 ml OP Oint 0.1%; 15 g & 50 g OP Crm 0.1%, 15 g & 50 g OP	Elocon Elocon Alcohol Free	2027
Montelukast	Tab 4 mg, 5 mg & 10 mg	Montelukast Viatris	2028
Morphine sulphate	Inj 5 mg, 10 mg, 15 mg & 30 mg per ml, 1 ml ampoule	Medsurge	2028
Nadolol	Tab 40 mg & 80 mg	Nadolol BNM	2027
Naloxone hydrochloride	Inj 400 mcg per ml, 1 ml ampoule	DBL Naloxone Hydrochloride	2027
Naltrexone hydrochloride	Tab 50 mg	Naltraccord	2026
Naphazoline hydrochloride	Eye drops 0.1%, 15 ml OP	Albalon	2027
Naproxen	Tab 250 mg & 500 mg Tab long-acting 750 mg Tab long-acting 1 g	Norflam Naprosyn SR 750 Naprosyn SR 1000	2027
Neostigmine metisulfate	Inj 2.5 mg per ml, 1 ml ampoule	Max Health	2027
Nevirapine	Tab 200 mg	Nevirapine Viatris	2027
Nicorandil	Tab 10 mg & 20 mg	Max Health	2028
Nitrofurantoin	Tab 50 mg Cap modified-release 100 mg	Nifuran Macrobid	2027 2026

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Sole Subsidised Supply (SSS) or Principal Supply Status (PSS) Products – Cumulative to March 2026

Generic Name	Presentation	Brand Name	Expiry Date*
Nystatin	Vaginal crm 100,000 u per 5 g with applicator(s), 75 g OP Oral liq 100,000 u per ml, 24 ml OP	Nilstat	2026
Octreotide long-acting	Inj depot 10 mg, 20 mg & 30 mg prefilled syringe	Sandostatin LAR	2027
Oestradiol	Patch 25 mcg, 50 mcg, 75 mcg & 100 mcg per day Gel (transdermal) 0.06% (750 mcg/actuation), 80 g OP	Estradiol TDP Mylan Estrogel	2027 31/10/2027
Oestradiol valerate	Tab 1 mg & 2 mg	Progynova	2028
Oestriol	Crm 1 mg per g with applicator, 15 g OP Tab 2 mg Pessaries 500 mcg	Ovestin	2026
Oil in Water Emulsion	Crm	Fatty Emulsion Cream (Evara)	2027
Olanzapine	Tab 2.5 mg, 5 mg and 10 mg Tab orodispersible 5 mg and 10 mg	Zypine Zypine ODT	2026
Olopatadine	**Eye drops 0.1%, 5 ml OP**	**Olopatadine Teva**	**2028**
Omeprazole	Cap 10 mg Cap 20 mg Cap 40 mg	Omeprazole actavis 10 Omeprazole actavis 20 Omeprazole actavis 40	2026
Ondansetron	Tab 4 mg & 8 mg Tab disp 4 mg and 8 mg	Periset Periset ODT	2028 2026
Ornidazole	Tab 500 mg	Arrow-Ornidazole	2027
Orphenadrine citrate	Tab 100 mg	Norflex	2027
Oxycodone hydrochloride	Inj 10 mg per ml, 1 ml & 2 ml ampoule Inj 50 mg per ml, 1 ml ampoule	Hameln	2027
Oxycodone hydrochloride	Tab controlled-release 5 mg, 10 mg, 20 mg, 40 mg & 80 mg	Oxycodone Sandoz	2027
Oxytocin	**Inj 5 iu & 10 iu per ml, 1 ml ampoule**	**Oxytocin BNM**	**2028**
Oxytocin with ergometrine maleate	Inj 5 iu with ergometrine maleate 500 mcg per ml, 1 ml ampoule	Syntometrine	2028
Paracetamol	Suppos 125 mg, 250 mg and 500 mg Tab 500 mg-bottle pack Tab 500 mg-blister pack	Gacet Noumed Paracetamol Pacimol	2026
Paracetamol with codeine	Tab paracetamol 500 mg with codeine phosphate 8 mg	Paracetamol + Codeine (Relieve)	2028
Paraffin	White soft, 450 g White soft, 2,500 g	EVARA White Soft Paraffin	2026
Paroxetine	Tab 20 mg	Loxamine	2028
Pazopanib	Tab 200 mg & 400 mg	Pazopanib Teva	2027
Pegfilgrastim	Inj 6 mg per 0.6 ml syringe	Ziextenzo	2028
Perindopril	Tab 2 mg, 4 mg & 8 mg	Coversyl	2027

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Sole Subsidised Supply (SSS) or Principal Supply Status (PSS) Products – Cumulative to March 2026

Generic Name	Presentation	Brand Name	Expiry Date*
Permethrin	Lotn 5%, 30 ml OP	A-Scabies	2026
Pethidine hydrochloride	Tab 50 mg	Noumed Pethidine	2028
Phenoxymethylpenicillin (Penicillin V)	Grans for oral liq 125 mg & 250 mg per 5 ml Cap 250 mg & 500 mg	AFT Cilicaine VK	2028 2027
Pimecrolimus	Crm 1%, 15 g OP	Elidel	2026
Pine tar with trolamine laurilsulfate and fluorescein	Soln 2.3% with trolamine laurilsulfate and fluorescein sodium	Pinetarsol	2026
Pioglitazone	Tab 15 mg, 30 mg & 45 mg	Vexazone	2027
Pneumococcal (PCV13) conjugate vaccine	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	Prevenar 13	2027
Pneumococcal (PPV23) polysaccharide vaccine	Inj 575 mcg in 0.5 ml prefilled syringe (25 mcg of each 23 pneumococcal serotype)	Pneumovax 23	2027
Poliomyelitis vaccine	Inj 80D antigen units in 0.5 ml syringe	IPOL	2027
Poloxamer	Oral drops 10%, 30 ml OP	Coloxyl	2026
Pomalidomide	Cap 1 mg, 2 mg, 3 mg and 4 mg	Pomolide	31/07/2027
Posaconazole	Oral liq 40 mg per ml, 105ml OP Tab modified-release 100 mg	Devatis Posaconazole Juno	2028
Potassium chloride	Tab long-acting 600 mg (8 mmol)	Span-K	2028
Potassium iodate	Tab 253 mg (150 mcg elemental iodine)	NeuroTabs	2026
Pramipexole hydrochloride	Tab 0.25 mg & 1 mg	Ramipex	2028
Pravastatin	Tab 20 mg and 40 mg	Clinect	2026
Prednisolone	Oral liq 5 mg per ml, 30 ml OP	Redipred	2027
Pregnancy tests – HCG urine	Cassette, 40 test OP	David One Step Cassette Pregnancy Test	2027
Prochlorperazine	Tab 5 mg	Nausafix	2026
Promethazine hydrochloride	Tab 10 mg & 25 mg	Allersoothe	2028
Propranolol	Tab 10 mg Tab 40 mg	Drofate IPCA-Propranolol	2027
Pyridoxine hydrochloride	Tab 25 mg	Vitamin B6 25	2026
Quetiapine	Tab 25 mg, 100 mg, 200 mg & 300 mg	Quetapel	2026
Quinapril	Tab 5 mg Tab 10 mg Tab 20 mg	Arrow-Quinapril 5 Arrow-Quinapril 10 Arrow-Quinapril 20	2027
Ramipril	Cap 1.25 mg, 2.5 mg, 5 mg & 10 mg	Tryzan	2027
Rifampicin	Cap 150 mg & 300 mg Oral liq 100 mg per 5 ml	Rifadin	2026
Rifaximin	Tab 550 mg	Xifaxan	2027

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Sole Subsidised Supply (SSS) or Principal Supply Status (PSS) Products – Cumulative to March 2026

Generic Name	Presentation	Brand Name	Expiry Date*
Riluzole	Tab 50 mg	Rilutek	2027
Risedronate sodium	Tab 35 mg	Risedronate Sandoz	2028
Risperidone	Tab 0.5 mg, 1 mg, 2 mg, 3 mg and 4 mg Oral liq 1 mg per ml, 30 ml	Risperidone (Teva) Risperon	2026
Rivaroxaban	Tab 10 mg, 15 mg & 20 mg	Xarelto	2026
Rivastigmine	Patch 4.6 mg per 24 hour Patch 9.5 mg per 24 hour	Rivastigmine Patch BNM 5 Rivastigmine Patch BNM 10	2027
Rizatriptan	Tab orodispersible 10 mg	Rizamelt	2026
Rosuvastatin	Tab 5 mg, 10 mg, 20 mg & 40 mg	Rosuvastatin Viatris	2026
Rotavirus oral vaccine	Oral susp live attenuated human rotavirus 1,000,000 CCID50 per dose, prefilled oral applicator	Rotarix	2027
Roxithromycin	Tab 150 mg & 300 mg	Arrow-Roxithromycin	2026
Salbutamol	Oral liq 400 mcg per ml	Ventolin	2027
Sildenafil	Tab 25 mg, 50 mg & 100 mg	Vedafil	2027
Simvastatin	Tab 20 mg, 40 mg and 80 mg Tab 10 mg	Simvastatin Viatris Simvastatin Mylan	2026
Sodium chloride	Inj 0.9%, 5 ml, 10 ml & 20 ml ampoule	Fresenius Kabi	2028
Sodium citrate with sodium lauryl sulphoacetate	Enema 90 mg with sodium lauryl sulphoacetate 9 mg per ml, 5 ml	Micolette	2028
Sodium citro-tartrate	Grans eff 4 g sachets	Ural	2026
Sodium cromoglicate	**Eye drops 2%, 10 ml OP**	**Allerfix**	**2028**
Sodium fusidate [fusidic acid]	Crm 2% & oint 2%, 5 g OP	Foban	2027
Sodium hyaluronate [hyaluronic acid]	Eye drops 1 mg per ml, 10 ml OP	Hylo-Fresh	2027
Solifenacin succinate	Tab 5 mg & 10 mg	Solifenacin succinate Max Health	2027
Somatropin	Inj 5 mg, 10 mg & 15 mg cartridge	Omnitrope	2027
Sotalol	Tab 80 mg & 160 mg	Mylan	2028
Spironolactone	**Tab 25 mg & 100 mg**	**Spiractin**	**2028**
Sumatriptan	Inj 12 mg per ml, 0.5 ml prefilled pen Tab 50 mg & 100 mg	Clustran Sumagran	2028 2027
Sunitinib	**Tab 12.5 mg & 25 mg**	**Sunitinib Rex**	**2027**
Tacrolimus	Oint 1 %; 30 g OP	Zematop	2026
Tamoxifen citrate	Tab 10 mg & 20 mg	Tamoxifen Sandoz	2026
Tamsulosin hydrochloride	Cap 400 mcg	Tamsulosin-Rex	2028
Temazepam	Tab 10 mg	Normison	2026
Tenofovir disoproxil	Tab 245 mg (300 mg as a maleate)	Tenofovir Disoproxil Viatris	2028

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Sole Subsidised Supply (SSS) or Principal Supply Status (PSS) Products – Cumulative to March 2026

Generic Name	Presentation	Brand Name	Expiry Date*
Tenoxicam	Tab 20 mg	Tilcotil	2028
Terbinafine	Tab 250 mg	Deolate	2026
Teriflunomide	Tab 14 mg	Teriflunomide Sandoz	2027
Testosterone	Gel (transdermal) 16.2 mg per g, 88 g OP	Testogel	2027
Tetrabenazine	Tab 25 mg	Motetis	2028
Ticagrelor	Tab 90 mg	Ticagrelor Sandoz	2027
Timolol	Eye drops 0.25% and 0.5%, 5 ml OP	Arrow-Timolol	2026
Tobramycin	Inj 40 mg per ml, 2 ml vial Soln for inhalation 60 mg per ml, 5 ml	Viatris Tobramycin BNM	2027 2026
Tramadol hydrochloride	Tab sustained-release 100 mg Tab sustained-release 150 mg Tab sustained-release 200 mg Cap 50 mg	Tramal SR 100 Tramal SR 150 Tramal SR 200 Arrow-Tramadol	2026
Trastuzumab (Herzuma)	Inj 150 mg vial and 440 mg vial	Herzuma	31/05/2027
Travoprost	Eye drops 0.004%, 2.5 ml OP	Travatan	2027
Tretinoin	Crm 0.5 mg per g, 50 g OP	ReTrieve	2027
Triamcinolone acetonide	Paste 0.1%, 5 g OP Crm 0.02%, 100 g OP Oint 0.02%, 100 g OP Inj 10 mg per ml, 1 ml ampoule Inj 40 mg per ml, 1 ml ampoule	Kenalog in Orabase Aristocort Kenacort-A 10 Kenacort-A 40	2026
Trimethoprim	Tab 300 mg	TMP	2027
Trimethoprim with sulphamethoxazole [co-trimoxazole]	Oral liq 8 mg sulphamethoxazole 40 mg per ml Tab trimethoprim 80 mg and sulphamethoxazole 400 mg	Deprim Trisul	2028 2027
Tuberculin PPD [mantoux] test	Inj 5 TU per 0.1 ml, 1 ml vial	Tubersol	2027
Ursodeoxycholic acid	Cap 250 mg	Ursosan	2026
Valaciclovir	Tab 500 mg & 1,000 mg	Vaclovir	2027
Valganciclovir	Tab 450 mg	Valganciclovir Viatris	2027
Vancomycin	Inj 500 mg vial	Vancomycin Viatris	2026
Varicella vaccine [chickenpox vaccine]	Inj 2000 PFU prefilled syringe plus vial	Varilrix	2027
Vinorelbine	Cap 20 mg, 30 mg & 80 mg	Vinorelbine Te Arai	2028
Voriconazole	Tab 50 mg & 200 mg	Vttack	2028
Zoledronic acid	Inj 0.05 mg per ml, 100 ml, bag Inj 4 mg per 5 ml, vial	Zoledronic Acid Viatris Zoledronic Acid Viatris	2028 2027
Zopiclone	Tab 7.5 mg	Zopiclone Actavis	2027

March 2026 changes are in bold type

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Check your Schedule for full details Schedule page ref	Subsidy (Mnfr's price) $	Per	Brand or Generic Mnfr ✔ **fully subsidised**

New Listings

Effective 1 March 2026

39 TRANEXAMIC ACID

Inj 100 mg per ml, 10 ml ampoule – Subsidy by endorsement.... 7.99 | 5 | ✔**Tranexamic-AFT**

a) Up to 5 inj available on a PSO
b) Only on a PSO
c) Subsidised only for use within a Primary Response in Medical Emergencies (PRIME) service or for the treatment of post-partum haemorrhage (PPH) and the PSO is endorsed accordingly.

40 TICAGRELOR – Special Authority see SA2530 – Retail pharmacy

✻ Tab 90 mg..... 20.35 | 56 | ✔**Ticagrelor Sandoz S29** S29

Wastage claimable

44 GLUCOSE [DEXTROSE]

Inj 5%, 100 ml bag – Subsidy by endorsement..... 97.00 | 50 | ✔**Fresenius Kabi**

a) Up to 50 inj available on a PSO
b) Only on a PSO
c) Subsidised only for use within a Primary Response in Medical Emergencies (PRIME) service and the PSO is endorsed accordingly.

Inj 10%, 500 ml bag – Subsidy by endorsement..... 126.00 | 18 | ✔**Baxter Glucose 10%**

a) Up to 18 inj available on a PSO
b) Only on a PSO
c) Subsidised only for use within a Primary Response in Medical Emergencies (PRIME) service and the PSO is endorsed accordingly.

52 FUROSEMIDE [FRUSEMIDE]

✻ Inj 10 mg per ml, 2 ml ampoule

– Up to 10 inj available on a PSO..... 3.97 | 10 | ✔**Furosemide-AFT**

120 TERIPARATIDE – Special Authority see SA1139 – Retail pharmacy

Inj 250 mcg per ml, 2.4 ml..... 490.00 | 1 | ✔**Forteo** S29

123 KETAMINE – Subsidy by endorsement

a) Up to 5 inj available on a PSO
b) Subsidised only for use within a Primary Response in Medical Emergencies (PRIME) service or to treat intractable pain in palliative care* and the prescription or PSO is endorsed accordingly.

Note: Indication marked with * is an unapproved indication

Inj 100 mg per ml, 2 ml vial ..... 91.98 | 5 | ✔**Ketalar**

124 METHOXYFLURANE – Subsidy by endorsement

a) Only on a PSO
b) Subsidised only for use within a Primary Response in Medical Emergencies (PRIME) service and the PSO is endorsed accordingly.

Soln for inhalation 999.9 mg per g, 3 ml bottle with inhaler device and activated carbon chamber

– Up to 2 packs available on a PSO ..... 54.00 | 1 OP | ✔**Penthrox**

Soln for inhalation 999.9 mg per g, 3 ml bottle

– Up to 10 bottles available on a PSO ..... 276.00 | 10 | ✔**Penthrox**

Check your Schedule for full details Schedule page ref	Subsidy (Mnfr's price) $	Per	Brand or Generic Mnfr ✔ fully subsidised

New Listings – effective 1 March 2026 (continued)

133 DROPERIDOL – Subsidy by endorsement
a) Up to 10 inj available on a PSO
b) Only on a PSO
c) Subsidised only for use within a Primary Response in Medical Emergencies (PRIME) service and the PSO is endorsed accordingly.

Inj 2.5 mg per ml, 1 ml ampoule	28.68	10	✔**Droperidol Medsurge**

135 OLANZAPINE – Safety medicine; prescriber may determine dispensing frequency

Tab orodispersible 10 mg	2.89	28	✔**Olanzapina Mylan Pharma** S29 ✔**Olanzapina Mylan** S29

Wastage claimable

281 PHARMACY SERVICES

✻ Brand switch fee	4.50	1 fee	✔**BSF Lyrica**

a) May only be claimed once per patient.
b) The Pharmacode for BSF Lyrica is 2723727.

288 DIABETIC ORAL FEED 1KCAL/ML – Special Authority see SA1095 – Hospital pharmacy [HP3]

Liquid (vanilla), 200 ml bottle	8.40	4	✔**Nutren Diabetes**

291 ORAL ELEMENTAL FEED 1KCAL/ML – Special Authority see SA1377 – Hospital pharmacy [HP3]

Powder (unflavoured), 80 g sachet	45.00	10	✔**Vivonex TEN**

316 INFLUENZA VACCINE

Inj 60 mcg in 0.5 ml syringe (quadrivalent vaccine)	120.00	10	✔**Influvac Tetra (2026 formulation)**

a) Maximum of 1 inj per prescription
b) Only on a prescription
c) No patient co-payment payable
d) Access criteria apply

Effective 9 February 2026

64 ILOPROST – Special Authority see SA2560 – Retail pharmacy

Nebuliser soln 10 mcg per ml, 2 ml	166.53	30	✔**Vebulis S29** S29

Wastage claimable

Effective 1 February 2026

8 SODIUM CROMOGLICATE

Cap 100 mg	125.70	100	✔**Allergoval** S29
	365.00		✔**Somex** S29

Wastage claimable

Changes to Restrictions, Chemical Names and Presentations

Effective 1 March 2026

41 ENOXAPARIN SODIUM – **Subsidy by endorsement; can be waived by** Special Authority see **SA2628** ~~SA2152 – Retail pharmacy~~ (addition of subsidy by endorsement waived by Special Authority and addition on PSO list)

Subsidy by Endorsement - Available on PSO for use within a Primary Response in Medical Emergencies (PRIME) service and the PSO is endorsed accordingly.

Inj 20 mg in 0.2 ml syringe	21.90	10	✔ **Clexane**
Inj 40 mg in 0.4 ml syringe.	29.74	10	✔ **Clexane**
Inj 60 mg in 0.6 ml syringe	42.47	10	✔ **Clexane**
Inj 80 mg in 0.8 ml syringe	56.62	10	✔ **Clexane**
Inj 100 mg in 1 ml syringe – **Up to 2 inj available on a PSO**	70.91	10	✔ **Clexane**
Inj 120 mg in 0.8 ml syringe	88.11	10	✔ **Clexane Forte**
Inj 150 mg in 1 ml syringe	100.70	10	✔ **Clexane Forte**

➽ **SA2628** ~~2152~~ Special Authority for Subsidy
Special Authority criteria is unchanged, only the form number has changed.

43 FILGRASTIM – Special Authority see **SA2613** ~~1259~~ – Retail pharmacy (amended Special Authority criteria)

Inj 300 mcg per 0.5 ml prefilled syringe	86.60	10	✔ **Nivestim**
Inj 480 mcg per 0.5 ml prefilled syringe	133.72	10	✔ **Nivestim**

➽ **SA2613** ~~1259~~ 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~~ **from any relevant practitioner**. 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 $< 0.5 \times 109$/L); or
5 Treatment of drug-induced prolonged neutropenia (ANC $< 0.5 \times 109$/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.

43 PEGFILGRASTIM – Special Authority see **SA2614** ~~1912~~ – Retail pharmacy (amended Special Authority criteria)

Inj 6 mg per 0.6 ml syringe	69.50	1	✔ **Ziextenzo**

➽ **SA2614** ~~1912~~ 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~~ **from any relevant practitioner**. 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 5%*).
Note: *Febrile neutropenia risk greater than or equal to 5% after taking into account other risk factors as defined by the European Organisation for Research and Treatment of Cancer (EORTC) guidelines.

47 LOSARTAN POTASSIUM WITH HYDROCHLOROTHIAZIDE (amended brand name)

✻ Tab 50 mg with hydrochlorothiazide 12.5 mg	7.25	90	✔ ~~Hyzaar~~ Losartan & Hydrochlorothiazide **(**Ipca**)**

52 FUROSEMIDE [FRUSEMIDE] (amended PSO quantity)

✻ Inj 10 mg per ml, 2 ml ampoule – Up to ~~5~~ **10** inj available on a PSO	2.40	5	✔ **Furosemide-Baxter**
	3.97	10	✔ **Furosemide-AFT**

Check your Schedule for full details Schedule page ref	Subsidy (Mnfr's price) $	Per	Brand or Generic Mnfr ✔ **fully subsidised**

Changes to Restrictions – effective 1 March 2026 (continued)

86 OESTRADIOL (removal of brand switch fee)

Patch 25 mcg per day	8.89	8	✔**Estradiol TDP Mylan**
	16.23		✔**Estradot**
~~a) Brand switch fee payable (Pharmacode 2717573)~~			
b) No more than 2 patch per week			
c) Only on a prescription			
Patch 50 mcg per day	9.26	8	✔**Estradiol TDP Mylan**
	15.79		✔**Estradot**
~~a) Brand switch fee payable (Pharmacode 2717573)~~			
b) No more than 2 patch per week			
c) Only on a prescription			
Patch 75 mcg per day	10.33	8	✔**Estradiol TDP Mylan**
	16.53		✔**Estradot**
~~a) Brand switch fee payable (Pharmacode 2717573)~~			
b) No more than 2 patch per week			
c) Only on a prescription			
Patch 100 mcg per day	10.59	8	✔**Estradiol TDP Mylan**
	16.18		✔**Estradot**
~~a) Brand switch fee payable (Pharmacode 2717573)~~			
b) No more than 2 patch per week			
c) Only on a prescription			

112 EFAVIRENZ – Special Authority see SA2139 – Retail pharmacy (addition of stat dispensing)
Note: No new patients to be initiated on efavirenz.

❋ Tab 600 mg	65.38	30	✔**Efavirenz Milpharm** S29

112 ETRAVIRINE – Special Authority see SA2139 – Retail pharmacy (addition of stat dispensing)

❋ Tab 200 mg	770.00	60	✔**Intelence**

112 NEVIRAPINE – Special Authority see SA2139 – Retail pharmacy (addition of stat dispensing)

❋ Tab 200 mg	198.25	60	✔**Nevirapine Viatris**
❋ Oral suspension 10 mg per ml	203.55	240 ml OP	✔**Viramune Suspension**

112 ABACAVIR SULPHATE – Special Authority see SA2139 – Retail pharmacy (addition of stat dispensing)

❋ Tab 300 mg	180.00	60	✔**Ziagen**

112 ABACAVIR SULPHATE WITH LAMIVUDINE – Special Authority see SA2139 – Retail pharmacy (addition of stat dispensing)
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	35.00	30	✔**Abacavir/Lamivudine Viatris**

112 EFAVIRENZ WITH EMTRICITABINE AND TENOFOVIR DISOPROXIL – Special Authority see SA2139 – Retail pharmacy (addition of stat dispensing)
Note: Efavirenz with emtricitabine and tenofovir disoproxil 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 245 mg (300 mg as a fumarate)	106.88	30	✔**TEEVIR** S29
❋ Tab 600 mg with emtricitabine 200 mg and tenofovir disoproxil 245 mg (300 mg as a maleate)	106.88	30	✔**Viatris**

▲ 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 at one time

Changes to Restrictions – effective 1 March 2026 (continued)

112 EMTRICITABINE – Special Authority see SA2139 – Retail pharmacy (addition of stat dispensing)
❋ Cap 200 mg ..... 307.20 30 ✔**Emtriva**

112 LAMIVUDINE – Special Authority see SA2139 – Retail pharmacy (addition of stat dispensing)
❋ Tab 150 mg ..... 98.00 60 ✔**Lamivudine Viatris**
❋ Oral liq 10 mg per ml ..... 102.50 240 ml OP ✔**3TC**

112 ZIDOVUDINE ~~[AZT]~~ – Special Authority see SA2139 – Retail pharmacy (addition of stat dispensing and amended chemical name)
❋ Cap 100 mg ..... 152.25 100 ✔**Retrovir**
❋ Oral liq 10 mg per ml ..... 30.45 200 ml OP ✔**Retrovir**

112 ZIDOVUDINE ~~[AZT]~~ WITH LAMIVUDINE – Special Authority see SA2139 – Retail pharmacy (addition of stat dispensing and amended chemical name)
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 ..... 92.40 60 ✔**Lamivudine/Zidovudine Viatris**

113 ATAZANAVIR SULPHATE – Special Authority see SA2139 – Retail pharmacy (addition of stat dispensing)
❋ Cap 150 mg ..... 102.50 60 ✔**Atazanavir Viatris**
❋ Cap 200 mg ..... 152.30 60 ✔**Atazanavir Viatris**

113 DARUNAVIR – Special Authority see SA2139 – Retail pharmacy (addition of stat dispensing)
❋ Tab 400 mg ..... 150.00 60 ✔**Darunavir Viatris**
❋ Tab 600 mg ..... 225.00 60 ✔**Darunavir Viatris**

113 LOPINAVIR WITH RITONAVIR – Special Authority see SA2139 – Retail pharmacy (addition of stat dispensing)
❋ Tab 200 mg with ritonavir 50 mg ..... 875.00 120 ✔**Lopinavir/Ritonavir Mylan**

113 RITONAVIR – Special Authority see SA2139 – Retail pharmacy (addition of stat dispensing)
❋ Tab 100 mg ..... 43.31 30 ✔**Norvir**

113 DOLUTEGRAVIR – Special Authority see SA2139 – Retail pharmacy (addition of stat dispensing)
❋ Tab 50 mg ..... 1,090.00 30 ✔**Tivicay**

113 DOLUTEGRAVIR WITH LAMIVUDINE – Special Authority see SA2139 – Retail pharmacy (addition of stat dispensing)
❋ Tab 50 mg with lamivudine 300 mg ..... 1,090.00 30 ✔**Dovato**

113 RALTEGRAVIR POTASSIUM – Special Authority see SA2139 – Retail pharmacy (addition of stat dispensing)
❋ Tab 400 mg ..... 1,090.00 60 ✔**Isentress**
❋ Tab 600 mg ..... 1,090.00 60 ✔**Isentress HD**

131 PREGABALIN – **Brand switch fee payable (Pharmacode 2723727)** (addition of brand switch fee)
Note: Not subsidised in combination with subsidised gabapentin
✳ Cap 25 mg ..... 2.25 56 ✔**Lyrica**
✔**Pregabalin Pfizer**
✳ Cap 75 mg ..... 2.65 56 ✔**Lyrica**
✔**Pregabalin Pfizer**
✳ Cap 150 mg ..... 4.01 56 ✔**Lyrica**
✔**Pregabalin Pfizer**
✳ Cap 300 mg ..... 7.38 56 ✔**Lyrica**
✔**Pregabalin Pfizer**

Changes to Restrictions – effective 1 March 2026 (continued)

161 PEGASPARGASE – PCT only – Special Authority see **SA2618** ~~1979~~ (amended Special Authority criteria – affected criteria shown only)

Inj 750 iu per ml, 5 ml vial	3,973.25	1	✔**Oncaspar LYO**

➽ **SA2618** ~~1979~~ Special Authority for Subsidy

Initial application – (Acute lymphoblastic leukaemia) only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for ~~12~~ **15** months for applications meeting the following criteria:
Both:
1 The patient has newly diagnosed acute lymphoblastic leukaemia; and
2 Pegaspargase to be used with a contemporary intensive multi-agent chemotherapy treatment protocol.

180 ETANERCEPT – Special Authority see **SA2619** ~~2399~~ – Retail pharmacy (amended Special Authority criteria – affected criteria shown only)

Inj 25 mg	690.00	4	✔**Enbrel**
Inj 25 mg autoinjector	690.00	4	✔**Enbrel**
Inj 50 mg autoinjector	1,050.00	4	✔**Enbrel**
Inj 50 mg prefilled syringe	1,050.00	4	✔**Enbrel**

➽ **SA2619** ~~2399~~ Special Authority for Subsidy

Initial application – (**Stills disease** - adult-onset ~~Stills disease~~ **(AOSD))** ~~only~~ from ~~a rheumatologist~~ **any relevant practitioner**. Approvals valid **without further renewal unless notified** ~~for 6 months~~ for applications meeting the following criteria:
Either:
1 Both:
  1.1 ~~Either:~~
    ~~1.2.1 The p~~**P**atient has had a~~n initial~~ Special Authority approval for adalimumab **or tocilizumab** for ~~adult-onset Still's disease~~ AOSD; ~~or~~ **and**
    ~~1.2.2 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 p~~**P**atient has experienced intolerable side effects ~~from adalimumab and/or tocilizumab~~; or
    1.2.2 ~~The p~~**P**atient has received insufficient benefit **to meet the renewal criteria** from at least a ~~three~~**3**-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~~ **received insufficient benefit from** at least 6 months of ~~gluco~~corticosteroids at a dose of at least 0.5 mg/kg **prednisone-equivalents**, ~~non-steroidal anti-inflammatory drugs~~ NSAIDs and methotrexate, **unless contraindicated**; and
  2.3 Patient has persistent symptoms of disabling poorly controlled and active disease.

~~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.~~

Initial application – (ankylosing spondylitis) ~~only~~ from any ~~rheumatologist~~ **relevant practitioner**. Approvals valid for 6 months for applications meeting the following criteria:
Either:
1 Both:
  1.1 ~~The p~~**P**atient has had a~~n initial~~ Special Authority approval for adalimumab for ankylosing spondylitis; and

continued...

Changes to Restrictions – effective 1 March 2026 (continued)

continued...

1.2 Either:

1.2.1 ~~The p~~**P**atient has experienced intolerable side effects ~~from adalimumab~~; or

1.2.2 ~~The p~~**P**atient 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 **radiologic imaging** ~~plain radiographs, CT or MRI scan;~~ and

2.4 ~~Patient's ankylosing spondylitis~~ **Disease** has not responded adequately to treatment with two or more ~~non-steroidal anti-inflammatory drugs (~~NSAIDs~~)~~ **(unless contraindicated)**, ~~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~~)~~ **score** of at least 6 on a ~~0~~**10-**point scale **completed after 3-month exercise trial before ceasing any previous pharmacological treatment and not more than 1 month before the application.**

~~Notes: The BASDAI must have been determined at the completion of the 3 month exercise trial, but prior to ceasing NSAID treatment~~ **and** ~~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~~
~~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~~

Renewal – (ankylosing spondylitis) **from any relevant practitioner** ~~only from a rheumatologist or Practitioner on the recommendation of a rheumatologist.~~ Approvals valid for **2 years** ~~6 months~~ for applications meeting the following criteria:
~~All of the following~~: **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~~

1 ~~2 Following 12 weeks' initial treatment and for subsequent renewals, Treatment has resulted in~~ ~~an improvement in~~ BASDAI **has improved from pre-treatment baseline** ~~of~~ **either by at least** 4 ~~or more~~ points ~~from pre-treatment baseline~~ on a ~~10 point~~ **10-point** scale, or ~~an improvement in BASDAI of~~ **by at least** 50%~~, whichever is less~~; and

~~3 Physician considers that the patient has benefited from treatment and that continued treatment is appropriate; and~~

2 ~~4 Etanercept to be administered at doses no greater than~~ **Maximum dose** 50 mg every 7 days.

Initial application – (**arthritis -** polyarticular course juvenile idiopathic ~~arthritis~~) ~~only from a named specialist, rheumatologist or Practitioner on the recommendation of a named specialist or rheumatologist.~~ from **any relevant practitioner**. Approvals valid for 6 months for applications meeting the following criteria:
~~Either~~ **Any of the following**:

1 Both:

1.1 ~~The p~~**P**atient has had a~~n initial~~ Special Authority approval for adalimumab for polyarticular course juvenile idiopathic arthritis (JIA); and

continued...

Changes to Restrictions – effective 1 March 2026 (continued)

continued...

1.2 Either:

1.2.1 ~~The p~~**P**atient has experienced intolerable side effects ~~from adalimumab~~; or

1.2.2 ~~The p~~**P**atient has received insufficient benefit ~~from adalimumab~~ to meet the renewal criteria ~~for adalimumab~~ for polyarticular course 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 has had polyarticular course JIA for 6 months duration or longer; and~~

~~2.3 Any of the following:~~

~~2.3.1~~ **2** At least 5 active joints and at least 3 joints with **pain, tenderness or a** limited range of motion~~, pain, or tenderness~~ after a 3-month trial of methotrexate at the maximum tolerated dose**, unless contraindicated**; or

~~2.3.2~~ **3** Moderate or high disease activity (cJADAS10 score of at least 2.5) after a 3-month trial of methotrexate at the maximum tolerated dose**, unless contraindicated**; or

~~2.3.3~~ **4** Low disease activity (cJADAS10 score between 1.1 and 2.5) after a 6-month trial of methotrexate.

Renewal – (**arthritis -** polyarticular course juvenile idiopathic ~~arthritis~~) **from any relevant practitioner** ~~only from a named specialist, rheumatologist or Practitioner on the recommendation of a named specialist or rheumatologist.~~ Approvals valid for **2 years** ~~6 months~~ for applications meeting the following criteria:

~~Both:~~

~~1 Subsidised as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance; and~~

~~2~~ Either**:**

1 ~~2.1~~ 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

2 ~~2.2~~ 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.

Initial application – (**arthritis -** oligoarticular course juvenile idiopathic ~~arthritis~~) ~~only from a named specialist or rheumatologist~~ from **any relevant practitioner**. Approvals valid for 6 months for applications meeting the following criteria:

~~Either~~ **Any of the following**:

1 Both:

1.1 ~~The p~~**P**atient has had a~~n initial~~ Special Authority approval for adalimumab for oligoarticular course juvenile idiopathic arthritis (JIA); and

1.2 Either:

1.2.1 ~~The p~~**P**atient has experienced intolerable side effects ~~from adalimumab~~; or

1.2.2 ~~The p~~**P**atient has received insufficient benefit ~~from adalimumab~~ to meet the renewal criteria ~~for adalimumab~~ for oligoarticular course 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 has had oligoarticular course JIA for 6 months duration or longer; and~~

~~3 Any of the following~~:

2 ~~3.1~~ At least 2 active joints with **pain, tenderness or a** limited range of motion~~, pain, or tenderness~~ after a 3-month trial of methotrexate ~~(~~at the maximum tolerated dose~~)~~**, unless contraindicated;** or

3 ~~3.2~~ Moderate or high disease activity (cJADAS10 score greater than 1.5) with poor prognostic features after a 3-month trial of methotrexate ~~(~~at the maximum tolerated dose~~)~~**, unless contraindicated.** ~~; or~~

~~3.3 High disease activity (cJADAS10 score greater than 4) after a 6-month trial of methotrexate.~~

Renewal – (**arthritis -** oligoarticular course juvenile idiopathic ~~arthritis~~) **from any relevant practitioner.** ~~only from a named specialist, rheumatologist or Practitioner on the recommendation of a named specialist or rheumatologist.~~ Approvals valid for **2 years** ~~6 months~~ for applications meeting the following criteria:

~~Both:~~

~~1 Subsidised as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance; and~~

continued...

Changes to Restrictions – effective 1 March 2026 (continued)

continued...

~~2~~ Either

1 ~~1.1~~ 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

2 ~~1.2~~ 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.

Initial application – (**arthritis** – psoriatic ~~arthritis~~) ~~only from a rheumatologist~~ **from any relevant practitioner.** Approvals valid for 6 months for applications meeting the following criteria:

Either:

1 Both:

1.1 ~~The p~~**P**atient has had a~~n initial~~ Special Authority approval for adalimumab or secukinumab for psoriatic arthritis; and

1.2 Either:

1.2.1 ~~The p~~**P**atient has experienced intolerable side effects ~~from adalimumab or secukinumab~~; or

1.2.2 ~~The p~~**P**atient has received insufficient benefit ~~from adalimumab or secukinumab~~ to meet the renewal criteria ~~for adalimumab or secukinumab~~ 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~~

2.1 ~~2.2~~ Patient has ~~tried and not responded to~~ **received insufficient benefit from** at least ~~three~~ **3** months of ~~oral or parenteral~~ methotrexate at ~~a dose of at least 20 mg weekly or a~~ maximum tolerated dose **unless contraindicated**; and

2.2 ~~2.3~~ Patient ~~tried and not responded to~~ **received insufficient benefit from** at least ~~three~~ **3** 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 dose~~s)~~ **unless contraindicated**; and

2.3 ~~2.4~~ Either:

2.3.1 ~~2.4.1~~ Patient has persistent symptoms of poorly controlled and active disease in at least 15 ~~swollen, tender~~ joints; or

2.3.2 ~~2.4.2~~ Patient has persistent symptoms of poorly controlled and active disease in at least ~~four~~ **4** joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip; and

2.4 ~~2.5~~ Any of the following:

2.4.1 ~~2.5.1~~ Patient has ~~a C-reactive protein~~ **CRP** ~~level~~ greater than 15 mg/L measured ~~no more than~~ **within** one month ~~prior to the date of this~~ **before the** application; or

2.4.2 ~~2.5.2~~ Patient has an ~~elevated erythrocyte sedimentation rate~~ (ESR) ~~greater than 25 mm per hour~~ **measured within one month before the application**; or

2.4.3 ~~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~~ **received** for more than ~~three~~ **3** months.

Renewal – (**arthritis** – psoriatic ~~arthritis~~) **from any relevant practitioner** ~~only from a rheumatologist or Practitioner on the recommendation of a rheumatologist.~~ Approvals valid for **2 years** ~~6 months~~ for applications meeting the following criteria:

~~All of the following~~ **Both:**

~~1 Either:~~

~~Applicant is a rheumatologist; or~~

~~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~~

1 ~~2~~ Either:

1.1 ~~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~~

1.2 ~~2.2 The patient demonstrates at~~ **A**t 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

2 ~~3 Etanercept to be administered at doses no greater than~~ **Maximum dose** 50 mg every 7 days.

Initial application – (pyoderma gangrenosum*****) ~~only~~ from **any relevant practitioner** ~~a dermatologist~~. Approvals valid **without further renewal unless notified** ~~for 4 months~~ for applications meeting the following criteria:

continued...

Changes to Restrictions – effective 1 March 2026 (continued)

continued...

~~All of the following:~~ **Both:**

~~1 Patient has pyoderma gangrenosum*; and~~

1 ~~2~~ Patient has received **insufficient benefit from** ~~three~~ **3** months of conventional therapy including a minimum of ~~three~~ **3** pharmaceuticals (e.g. prednisone, ciclosporin, azathioprine, or methotrexate) ~~and not received an adequate response~~. **Where conventional pharmaceuticals are contraindicated, a 3 month trial has occurred of those that are not contraindicated;** and

2 ~~3 A m~~**M**aximum of 8 doses **every 4 months**.

Note: Indications marked with * are unapproved indications.

~~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 8 doses.~~

Initial application – (~~A~~**a**rthritis - rheumatoid) ~~only~~ from **any relevant practitioner** ~~a rheumatologist~~. Approvals valid for 6 months for applications meeting the following criteria:

Either:

1 Both:

1.1 ~~The p~~ **P**atient has had a~~n initial~~ Special Authority approval for adalimumab for rheumatoid arthritis; and

1.2 Either:

1.2.1 ~~The p~~**P**atient has experienced intolerable side effects; or

1.2.2 ~~The p~~**P**atient has received insufficient benefit to meet the renewal criteria for rheumatoid arthritis; or

2 All of the following:

2.1 Patient has had rheumatoid arthritis (either confirmed by ~~radiology~~ **radiologic** imaging, or the patient is cyclic citrullinated peptide (CCP) antibody positive) ~~for six months duration or longer~~; and

~~2.2 Treatment is to be use as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance; and~~

2.2 ~~2.3~~ Patient has ~~tried and not responded to~~ **received insufficient benefit from** at least **3** ~~three~~ months of methotrexate at a maximum tolerated dose (unless contraindicated); and

2.3 ~~2.4~~ Patient has ~~tried and not responded to~~ **received insufficient benefit from** at least **3** ~~three~~ months of methotrexate in combination with sulfasalazine and hydroxychloroquine sulphate (at maximum tolerated doses unless contraindicated); and

2.4 ~~2.5~~ Either:

2.4.1 ~~2.5.1~~ Patient has ~~tried and not responded to~~ **received insufficient benefit from** at least **3** ~~three~~ months of methotrexate in combination with the maximum tolerated dose of ciclosporin**, unless contraindicated**; or

2.4.2 ~~2.5.2~~ Patient has t~~ried and not responded to~~ **received insufficient benefit from** at least **3** ~~three~~ months of therapy at the maximum tolerated dose of leflunomide alone or in combination with methotrexate**, unless contraindicated;** and

2.5 ~~2.6~~ Either:

2.5.1 ~~2.6.1~~ Patient has persistent symptoms of poorly controlled and active disease in at least 15 ~~swollen~~ joints; or

2.5.2 ~~2.6.2~~ Patient has persistent symptoms of poorly controlled and active disease in at least **4** ~~four~~ joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip.

Renewal – (**Aa**rthritis - rheumatoid) from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

~~All of the following~~ **Both**:

~~1 Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance; and~~

1 ~~2~~ Either:

1.1 ~~2.1~~ Following 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

continued...

Changes to Restrictions – effective 1 March 2026 (continued)

continued...

1.2 ~~2.2~~ 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

2 ~~3~~ Etanercept to be administered at doses no greater than **Maximum dose** 50 mg every 7 days.

Initial application – (~~severe chronic~~ p**P**laque psoriasis) ~~only~~ from ~~a dermatologist~~ ~~or~~ any relevant practitioner ~~on the recommendation of a dermatologist~~. Approvals valid for ~~4~~ **6** months for applications meeting the following criteria:

Either:

1 Both:
- 1.1 ~~The p~~**P**atient has had a~~n initial~~ Special Authority approval for adalimumab for ~~severe chronic~~ plaque psoriasis; and
- 1.2 Either:
  - 1.2.1 ~~The p~~**P**atient has experienced intolerable side effects ~~from adalimumab~~; or
  - 1.2.2 ~~The p~~**P**atient has received insufficient benefit ~~from etanercept~~ to meet the renewal criteria for ~~severe chronic~~ plaque psoriasis; or

2 All of the following:
- 2.1 Any of the following:
  - 2.1.1 Patient has "whole body" ~~severe chronic~~ plaque psoriasis with a ~~Psoriasis Area and Severity Index~~ ~~(~~PASI~~)~~ score of greater than 10 ~~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~~; or
  - 2.1.3 Patient has ~~severe chronic~~ localised genital or flexural plaque psoriasis ~~where the plaques or lesions have been present for at least 6 months form the time of initial diagnosis, and~~ with a ~~Dermatology Life Quality Index (~~DLQI~~)~~ score greater than 10; and
- 2.2 Patient has ~~tried, but had an inadequate response~~ ~~(see Note) to~~ **received insufficient benefit from (see Note)**, or has experienced intolerable side effects from, at least ~~three~~ **3** of the following at maximum tolerated doses (unless contraindicated): phototherapy, methotrexate, ciclosporin, or acitretin; and
- 2.3 A PASI assessment or ~~Dermatology Quality of Life Index (~~DLQI~~)~~ 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~~ **within** 1 month **of stopping** ~~following cessation of each prior treatment course~~ **that treatment**; and
- 2.4 The most recent PASI or DLQI assessment is ~~no more than~~ **within 1** month ~~old at the time of~~ **before the** application.

Note: "~~Inadequate response~~ **Insufficient benefit**" 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, foot, genital or flexural areas at least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very severe, and for the face, palm of a hand or sole of a foot the skin area affected is 30% or more of the face, palm of a hand or sole of a foot~~,~~ a**A**s assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment.

Renewal – (~~severe chronic~~ p**P**laque psoriasis) from any relevant practitioner.~~-~~Approvals valid for **2 years** ~~6 months~~ for applications meeting the following criteria:

Both:

1 Any of the following:
- 1.1 Both:
  - 1.1.1 Patient had "whole body" ~~severe chronic~~ plaque psoriasis at the start of treatment; and
  - 1.1.2 Either:
    - 1.1.2.1 ~~Following each prior etanercept treatment course the p~~**P**atient 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
    - 1.1.2.2 ~~Following each prior etanercept treatment course the p~~**P**atient has a ~~Dermatology Quality of Life Index~~ ~~(~~DLQI~~)~~ improvement of 5 or more, ~~when~~ compared with the pre-treatment baseline~~ value~~; or

continued...

Changes to Restrictions – effective 1 March 2026 (continued)

continued...

1.2 Both:

1.2.1 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

1.2.2 Either:

1.2.2.1 ~~Following each prior etanercept treatment course the p~~**P**atient 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 **pre-**treatment ~~course~~ baseline ~~values~~; or

1.2.2.2 ~~Following each prior etanercept treatment course the p~~**P**atient 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~~; or

1.3 Both:

1.3.1 Patient has ~~severe chronic~~ localised genital or flexural plaque psoriasis at the start of treatment; and

1.3.2 Either:

1.3.2.1 ~~The p~~**P**atient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, ~~as~~ compared to the pre-treatment baseline ~~value~~; or

1.3.2.2 Patient has a ~~Dermatology Quality of Life Index (~~DLQI~~)~~ improvement of 5 or more, ~~as~~ compared to **the pre-treatment** baseline ~~DLQI prior to commencing etanercept~~; and

2 ~~Etanercept to be administered at doses no greater than~~ **Maximum dose** 50 mg every 7 days.

~~Note: A treatment course is defined as a minimum of 12 weeks etanercept treatment~~

Initial application – (undifferentiated spondyloarthritis*****) ~~only~~ from ~~a rheumatologist~~ **any relevant practitioner**. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

1 Patient has undifferentiated peripheral spondyloarthritis~~*~~ with active peripheral joint arthritis in at least ~~four~~ **4** joints from the following: wrist, elbow, knee, ankle, and either shoulder, or hip; and

2 Patient has ~~tried and not responded to~~ **received insufficient benefit from** at least ~~three~~ **3** months of ~~oral or parenteral~~ **each of** methotrexate, **sulfasalazine, and leflunomide** at ~~a dose of at least 20 mg weekly or a~~ maximum tolerated dose**s, unless contraindicated**; and

~~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 maximum tolerated dose); and~~

~~4 Patient has tried and not responded to at least three months of leflunomide at a dose of up to 20 mg daily (or maximum tolerated dose); and~~

3 ~~5~~ Any of the following:

3.1 ~~5.1~~ Patient has a ~~C-reactive protein~~ **CRP** level greater than 15 mg/L measured ~~no more than~~ **within** one month ~~prior to the date of this~~ **before the** application; or

3.2 ~~5.2~~ Patient has an ~~elevated erythrocyte sedimentation rate (~~ESR~~)~~ greater than 25 mm per hour measured ~~no more than~~ **within** one month ~~prior to the date of this~~ **before the** application; or

3.3 ~~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~~ **received** for more than three months.

Note: Indications marked with * are unapproved indications.

Renewal – (undifferentiated spondyloarthritis*****) **from any relevant practitioner** ~~only from a rheumatologist or Practitioner on the recommendation of a rheumatologist.~~ Approvals valid for **2 years** ~~6 months~~ for applications meeting the following criteria:

~~All of the following~~ **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~~

1 ~~2~~ Either:

1.1 ~~2.1~~ Following ~~3 to 4 months'~~ initial treatment, the patient **has experienced** 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

continued...

Changes to Restrictions – effective 1 March 2026 (continued)

continued...

1.2 ~~2.2 The p~~**P**atient ~~demonstrates~~ **has experienced** 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

2 ~~3 Etanercept to be administered at doses no greater than~~ **Maximum dose** 50 mg ~~dose~~ every 7 days.

208 INFLIXIMAB – PCT only – Special Authority see **SA2620** ~~2487~~ (amended Special Authority criteria – affected criteria shown only)

Inj 100 mg	428.00	1	✔**Remicade**
Inj 1 mg for ECP	4.40	1 mg	✔**Baxter**

➽ **SA2620** ~~2487~~ Special Authority for Subsidy

Initial application – (ankylosing spondylitis) ~~only~~ from ~~a rheumatologist or Practitioner on the recommendation of a rheumatologist~~ **any relevant practitioner**. Approvals valid for ~~3~~ **6** months for applications meeting the following criteria:
~~Both~~ **All of the following**:

1 Patient has had a~~n initial~~ Special Authority approval for adalimumab ~~and/~~or etanercept for ankylosing spondylitis; and
2 Either:
  2.1 ~~The p~~**P**atient has experienced intolerable side effects ~~from a reasonable trial of adalimumab and/or etanercept~~; or
  2.2 ~~Following 12 weeks of adalimumab and/or etanercept treatment, the p~~**P**atient **has received insufficient benefit** ~~did not to~~ meet the renewal criteria ~~for adalimumab and/or etanercept~~ for ankylosing spondylitis; **and**
3 Following initial induction doses, maximum dose 5mg/kg every 6-8 weeks.

Renewal – (ankylosing spondylitis) ~~only~~ from any **relevant practitioner** ~~a rheumatologist or Practitioner on the recommendation of a rheumatologist.~~ Approvals valid for **2 years** ~~6 months~~ for applications meeting the following criteria:
~~All of the following:~~ **Both:**

1 ~~Following 12 weeks of infliximab treatment~~, BASDAI has improved **from pre-treatment baseline either** by **at least** 4 ~~or more~~ points ~~from pre-infliximab baseline~~ on a ~~10 point~~ **10-point** scale, or by **at least** 50%~~, whichever is less~~; and
~~2 Physician considered that the patient has benefited from treatment and that continued treatment is appropriate; and~~
2 ~~3 Infliximab is to be administered at doses no greater than~~ **Maximum dose** 5mg/kg every 6-8 weeks.

Initial application – (~~chronic~~ ocular inflammation – **chronic***) from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:
Either:

1 Both:
  1.1 ~~The p~~**P**atient has had a~~n initial~~ Special Authority for adalimumab for chronic ocular inflammation; and
  1.2 Either:
    1.2.1 ~~The p~~**P**atient has experienced intolerable side effects ~~from adalimumab~~; or
    1.2.2 ~~The p~~**P**atient has received insufficient benefit ~~from adalimumab~~ to meet the renewal criteria ~~for adalimumab~~ for chronic ocular inflammation; or
2 Both:
  2.1 Patient has severe uveitis **with a severe risk of vision loss** uncontrolled ~~with~~ **by** treatment **with** ~~of~~ **cortico**steroids and other immunosuppressants ~~with a severe risk of vision loss~~; and
  2.2 Any of the following:
    2.2.1 Patient is 18 years or older and treatment with at least two other immunomodulatory agents has ~~proven~~ **been** ineffective **or are contraindicated**; or
    2.2.2 Patient is under 18 years and treatment with methotrexate has ~~proven~~ **been** ineffective, **is contraindicated** or is not tolerated at a therapeutic dose; or
    2.2.3 Patient is under 8 years and treatment with **cortico**steroids or methotrexate has ~~proven~~ **been** ineffective, **is contraindicated** or is not tolerated at a therapeutic dose; or disease requires control to prevent irreversible vision loss prior to achieving a therapeutic dose of methotrexate.

Note: Indications marked with * are unapproved indications.

Renewal – (~~chronic~~ ocular inflammation – **chronic***) from any relevant practitioner. Approvals valid for **2 years** ~~12 months~~ for applications meeting the following criteria:
Any of the following:

continued...

Changes to Restrictions – effective 1 March 2026 (continued)

continued...

1 ~~The p~~**P**atient **has received** ~~had~~ a good clinical response following 3 initial doses; or
2 Following each **2 year** ~~12 month~~ treatment period, the patient **has experienced** ~~had~~ a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema); or
3 Following each **2 year** ~~12 month~~ treatment period, the patient **has** a sustained **cortico**steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or **cortico**steroid drops less than twice daily if under 18 years old.

Note: A trial withdrawal should be considered after every 24 months of stability, unless the patient is deemed to have extremely high risk of irreversible vision loss if infliximab is withdrawn.

Indications marked with * are unapproved indications

Initial application – (plaque psoriasis) ~~only~~ from ~~a dermatologist or any relevant practitioner on the recommendation of a dermatologist~~ **any relevant practitioner**. Approvals valid for ~~3~~ **6** months for applications meeting the following criteria:

Either:

1 Both:
  1.1 ~~The p~~**P**atient had a~~n initial~~ Special Authority approval for adalimumab, etanercept or secukinumab for ~~severe chronic~~ plaque psoriasis; and
  1.2 Either:
    1.2.1 ~~The p~~**P**atient **has** experienced intolerable side effects ~~from adalimumab, etanercept or secukinumab~~; or
    1.2.2 ~~The p~~**P**atient **has** received insufficient benefit ~~from adalimumab, etanercept or secukinumab~~ to meet the renewal criteria ~~for adalimumab, etanercept or secukinumab~~ for ~~severe chronic~~ plaque psoriasis; or
2 All of the following:
  2.1 Any of the following:
    2.1.1 Patient **has** "whole body" ~~severe chronic~~ plaque psoriasis with a ~~Psoriasis Area and Severity Index (~~PASI~~)~~ score of greater than 10 ~~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~~; or
    2.1.3 Patient **has** ~~severe chronic~~ localised genital or flexural plaque psoriasis ~~where the plaques or lesions have been present for at least 6 months from the time of initial diagnosis, and~~ with a ~~Dermatology Life Quality Index (~~DLQI~~)~~ score greater than 10; and
  2.2 Patient **has** ~~tried, but had an inadequate response~~ **received insufficient benefit** (see Note)-or has experienced intolerable side effects from~~,~~ at least ~~three~~ **3** 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~~ **within** 1 month ~~following cessation of each prior treatment course~~ **of stopping that treatment;** and
  2.4 The most recent PASI assessment is within 1 month before the application.

Note: "~~Inadequate response~~ **Insufficient benefit**" 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, foot, genital or flexural areas at least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very severe, and for the face, palm of a hand or sole of a foot 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 – (plaque psoriasis) from any relevant practitioner. Approvals valid for **2 years** ~~6 months~~ for applications meeting the following criteria:

Both:

1 Any of the following:
  1.1 Both:
    1.1.1 Patient had "whole body" ~~severe chronic~~ plaque psoriasis at the start of treatment; and

continued...

Changes to Restrictions – effective 1 March 2026 (continued)

continued...

1.1.2 ~~Following each prior infliximab treatment course the p~~**P**atient **has** a PASI score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-infliximab ~~treatment~~ baseline ~~value~~; or

1.2 Both:

1.2.1 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

1.2.2 Either:

1.2.2.1 ~~Following each prior infliximab treatment course p~~**P**atient **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 pre-**infliximab** ~~treatment course~~ baseline ~~values~~; or

1.2.2.2 ~~Following each prior infliximab treatment course the p~~**P**atient **has** a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-infliximab ~~treatment~~ baseline ~~value~~; or

1.3 Both:

1.3.1 Patient had ~~severe chronic~~ localised genital or flexural plaque psoriasis at the start of treatment; and

1.3.2 Either:

1.3.2.1 ~~The p~~**P**atient **has** experienced a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline ~~value~~; or

1.3.2.2 ~~The p~~**P**atient **has** a ~~Dermatology Quality of Life Index (~~DLQI~~)~~ improvement of 5 or more, as compared to **the pre-infliximab** baseline ~~DLQI prior to commencing infliximab~~; and

2 ~~Infliximab to be administered at doses no greater than~~ **Maximum dose** 5mg/kg every 8 weeks.

Initial application – (**arthritis -** psoriatic ~~arthritis~~) ~~only~~ from ~~a rheumatologist or Practitioner on the recommendation of a rheumatologist~~ **any relevant practitioner**. Approvals valid for ~~4~~ **6** months for applications meeting the following criteria: ~~Both~~ **All of the following:**

1 ~~The p~~**P**atient has had ~~an initial~~ Special Authority approval for adalimumab**,** ~~and~~/or etanercept**,** ~~and/~~or secukinumab for psoriatic arthritis; and

2 Either:

2.1 ~~The p~~**P**atient **has** experienced intolerable side effects ~~from adalimumab and/or etanercept and/or secukinumab~~; or

2.2 ~~Following 3-4 months' initial treatment with adalimumab and/or etanercept and/or secukinumab, the p~~**P**atient **has received insufficient benefit** ~~did not~~ **to** meet the renewal criteria ~~for adalimumab, and/or etanercept and/or secukinumab~~ for psoriatic arthritis; **and**

3 Following initial induction doses, maximum dose 5mg/kg every 8 weeks.

Renewal – (**arthritis -** psoriatic ~~arthritis~~) ~~only~~ from **any relevant practitioner** ~~a rheumatologist or Practitioner on the recommendation of a rheumatologist~~. Approvals valid for **2 years** ~~6 months~~ for applications meeting the following criteria: Both:

1 Either:

1.1 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

1.2 ~~The patient demonstrates at~~ **At** least a continuing 30% improvement in active joint count from baseline ~~and a clinically significant response to prior infliximab treatment in the opinion of the treating physician~~; and

2 ~~Infliximab to be administered at doses no greater than~~ **Maximum dose** 5 mg/kg every 8 weeks.

Initial application – (**arthritis -** rheumatoid ~~arthritis~~) ~~only~~ from ~~a rheumatologist or Practitioner on the recommendation of a rheumatologist~~ **any relevant practitioner.** Approvals valid for ~~4~~ **6** months for applications meeting the following criteria: All of the following:

1 ~~The p~~**P**atient has had ~~an initial~~ Special Authority approval for adalimumab ~~and/~~or etanercept for rheumatoid arthritis; and 2 Either:

2.1 ~~The p~~**P**atient has experienced intolerable side effects ~~from a reasonable trial of adalimumab and/or etanercept~~; or

2.2 ~~Following at least a four month trial of adalimumab and/or etanercept, the The p~~**P**atient **has received insufficient benefit** ~~did not~~ **to** meet the renewal criteria for ~~adalimumab and/or etanercept~~ **rheumatoid arthritis**; and

3 ~~Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance.~~ **Following initial induction doses, maximum dose 3mg/kg every 8 weeks.**

continued...

Changes to Restrictions – effective 1 March 2026 (continued)

continued...

Renewal – (**arthritis -** rheumatoid ~~arthritis~~) ~~only~~ from **any relevant practitioner** ~~a rheumatologist or Practitioner on the recommendation of a rheumatologist~~. Approvals valid for **2 years** ~~6 months~~ for applications meeting the following criteria:
~~All of the following~~ **Both**:

~~1 Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance; and~~

1 Either:
- 1.1 Following ~~3 to 4 months'~~ initial treatment, the patient has **experienced** 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
- 1.2 ~~The p~~**P**atient ~~demonstrates~~ **has experienced** 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

2 ~~Infliximab to be administered at doses no greater than~~ **Maximum dose** 3 mg/kg every 8 weeks.

Initial application – (~~severe~~ Behcet~~'s~~ disease) from any relevant practitioner. Approvals valid **without further renewal unless notified** ~~for 4 months~~ for applications meeting the following criteria:
All of the following:

~~1~~ ~~The p~~**P**atient has severe Behcet~~'s~~ disease which is significantly impacting ~~the patient's~~ their quality of life ~~(see Notes)~~; and

2 Either:
- 2.1 ~~The p~~**P**atient **has** severe ocular, neurological and/or vasculitic symptoms and has ~~not responded adequately to~~ **received insufficient benefit from** ~~one~~ **1** or more treatment(s) appropriate for the particular symptom(s) ~~(see Notes)~~; or
- 2.2 ~~The p~~**P**atient **has** severe gastrointestinal, rheumatologic and/or mucocutaneous symptoms and has ~~not responded adequately to~~ **received insufficient benefit from 2** ~~two~~ or more treatment**s** appropriate for the particular symptom(s) ~~(see Notes)~~; and

3 Following initial loading doses, maximum dose 5mg/kg every 8 weeks.

~~4 The patient is experiencing significant loss of quality of life.~~

~~Notes: Behcet's disease diagnosed according to the International Study Group for Behcet's Disease. Lancet 1990;335(8697):1078-80. Quality of life measured using an appropriate quality of life scale such as that published in Gilworth et al J Rheumatol. 2004;31:931-7. Treatments appropriate for the particular symptoms are those that are considered standard conventional treatments for these symptoms, for example intravenous/oral steroids and other immunosuppressants for ocular symptoms; azathioprine, steroids, thalidomide, interferon alpha and ciclosporin for mucocutaneous symptoms; and colchicine, steroids and methotrexate for rheumatological symptoms.~~

~~Renewal – (severe Behcet's disease) from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:~~
~~Both:~~
~~1 Patient has had a good clinical response to initial treatment with measurably improved quality of life; and~~
~~2 Infliximab to be administered at doses no greater than 5 mg/kg every 8 weeks.~~

Initial application – (~~severe~~ ocular inflammation – **severe***) from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:
Either:

1 Both:
- 1.1 ~~The p~~**P**atient **has** had an initial Special Authority approval for adalimumab for severe ocular inflammation; and
- 1.2 Either:
  - 1.2.1 ~~The p~~**P**atient **has** experienced intolerable side effects ~~from adalimumab~~; or
  - 1.2.2 ~~The p~~**P**atient **has** received insufficient benefit ~~from adalimumab~~ to meet the renewal criteria ~~for adalimumab~~ for severe ocular inflammation; or

2 Both:
- 2.1 Patient has severe, vision-threatening ocular inflammation requiring rapid control; and
- 2.2 Any of the following:
  - 2.2.1 Treatment with high-dose **IV cortico**steroids ~~(intravenous methylprednisolone)~~ followed by high dose oral **cortico**steroids has ~~proven~~ **been** ineffective at controlling symptoms; or

continued...

Changes to Restrictions – effective 1 March 2026 (continued)

continued...

2.2.2 Patient developed new inflammatory symptoms while receiving high dose **cortico**steroids; or

2.2.3 Patient is aged under 8 years and treatment with high dose oral **cortico**steroids and other immunosuppressants has ~~proven~~ **been** ineffective at controlling symptoms**; or**

2.2.3 High dose corticosteroids are contraindicated.

Note: Indications marked with * are unapproved indications.

Renewal – (~~severe~~ ocular inflammation – **severe***) from any relevant practitioner. Approvals valid for **2 years** ~~12 months~~ for applications meeting the following criteria:

Any of the following:

1 ~~The p~~**P**atient **has** ~~had~~ **received** a good clinical response following 3 initial doses; or

2 Following each **2 year** ~~12 month~~ treatment period, the patient has **experienced** ~~had~~ a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema); or

3 Following each **2 year** ~~12 month~~ treatment period, patient has a sustained **cortico**steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or **cortico**steroid drops less than twice daily if under 18 years old.

Note: A trial withdrawal should be considered after every 24 months of stability, unless the patient is deemed to have extremely high risk of irreversible vision loss if infliximab is withdrawn.

Indications marked with * are unapproved indications.

Initial application – (pyoderma gangrenosum***) ~~only~~ from **any relevant practitioner** ~~a dermatologist~~. Approvals valid **without further renewal unless notified** ~~for 4 months~~ for applications meeting the following criteria:

~~All of the following:~~ **Both:**

~~1 Patient has pyoderma gangrenosum*; and~~

1 ~~2~~ Patient **has** received **insufficient benefit from** ~~three~~ **3** months of conventional therapy including a minimum of ~~three~~ **3** pharmaceuticals (e.g. prednisone, ciclosporin, azathioprine, or methotrexate) ~~and not received an adequate response~~. **Where conventional pharmaceuticals are contraindicated, a 3-month trial has occurred of those that are not contraindicated;** and

2 ~~3 A m~~**M**aximum of 8 doses **every 4 months**.

Note: Indications marked with * are unapproved indications.

~~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 8 doses.~~

Changes to Restrictions – effective 1 March 2026 (continued)

221 PALIVIZUMAB – PCT only – Special Authority see **SA2621** ~~2419~~ (amended Special Authority criteria – affected criteria shown only)

Inj 100 mg per ml, 1 ml vial ..... 1,700.00 1 ✔**Synagis**

➽ **SA2621** ~~2419~~ Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid for ~~6~~ **12** months for applications meeting the following criteria:

Both:

1 Palivizumab to be administered during the annual RSV season; and

2 Either:

2.1 Both:

2.1.1 Infant was born in the last 12 months; and

2.1.2 Infant was born at less than 32 weeks zero days' gestation; or

2.2 Both:

2.2.1 Child was born in the last 24 months; and

2.2.2 Any of the following:

2.2.2.1 Child has severe lung, airway, neurological or neuromuscular disease that requires ongoing ventilatory/respiratory support (see Note A) in the community; or

2.2.2.2 Both:

2.2.2.2.1 Child has haemodynamically significant heart disease; and

2.2.2.2.2 Any of the following:

2.2.2.2.2.1 Child has unoperated simple congenital heart disease with significant left to right shunt (see Note B); or

2.2.2.2.2.2 Child has unoperated or surgically palliated complex congenital heart disease; or

2.2.2.2.2.3 Child has severe pulmonary hypertension (see Note C); or

2.2.2.2.2.4 Child has moderate or severe left ventricular (LV) failure (see Note D); or

2.2.2.3 Child has severe combined immune deficiency, confirmed by an immunologist, but has not received a stem cell transplant; or

2.2.2.4 Child has inborn errors of immunity (see Note E) that increase susceptibility to life-threatening viral respiratory infections, confirmed by an immunologist.

Changes to Restrictions – effective 1 March 2026 (continued)

223 RITUXIMAB (MABTHERA) – PCT only – Specialist – Special Authority see **SA2622** ~~2552~~ (amended Special Authority criteria – affected criteria shown only)

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 (Mabthera)**

➽ **SA2622** ~~2552~~ Special Authority for Subsidy

Initial application – (**arthritis** - rheumatoid ~~arthritis~~ - TNF inhibitors contraindicated) from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

1 Treatment with a Tumour Necrosis Factor alpha inhibitor is contraindicated; and

2 Patient has had ~~severe and active erosive~~ rheumatoid arthritis (either confirmed by ~~radiology~~ **radiologic** imaging, or the patient is ~~cyclic citrullinated peptide (~~CCP~~)~~ antibody positive) ~~for six months duration or longer~~; and

3 ~~Patient has tried and~~ **Disease has** not responded to at least **3**~~three~~ months of ~~oral or parenteral~~ methotrexate at a dose of at least 20 mg weekly or a maximum tolerated dose**, unless contraindicated**; and

4 ~~Patient has tried and~~ **Disease has** not responded to at least **3**~~three~~ months of ~~oral or parenteral~~ methotrexate in combination with sulfasalazine and hydroxychloroquine sulphate (at maximum tolerated doses)**, unless contraindicated**; and

5 ~~Any of the following~~ **Either**:

5.1 ~~Patient has tried and~~ **Disease has** not responded to at least **3** ~~three~~ months of ~~oral or parenteral~~ methotrexate in combination with the maximum tolerated dose of ciclosporin**, unless contraindicated**; or

~~5.2 Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with intramuscular gold; or~~

5.2 ~~5.3 Patient has tried and~~ **Disease has** not responded to at least **3** ~~three~~ months of therapy at the maximum tolerated dose of leflunomide alone or in combination with ~~oral or parenteral~~ methotrexate**, unless contraindicated**; and

6 Either:

6.1 Patient has persistent symptoms of poorly controlled and active disease in at least 20 ~~swollen, tender~~ joints; or

6.2 Patient has persistent symptoms of poorly controlled and active disease in at least ~~four~~ **4** joints from the following: wrist, elbow, knee, ankle, ~~and either~~ shoulder**,** or hip; and

7 Either:

7.1 Patient has ~~a C-reactive protein~~ **CRP** ~~level~~ greater than 15 mg/L measured ~~no more than~~ **within** one month ~~prior to the date of this~~ **before the** application; or

7.2 ~~C-reactive protein levels~~ **CRP** not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day ~~and has done so~~ **received** for more than **3**~~three~~ months; and

~~8 Either:~~

~~8.1 Rituximab to be used as an adjunct to methotrexate or leflunomide therapy; or~~

~~8.2 Patient is contraindicated to both m~~**M**~~ethotrexate and leflunomide~~ **are contraindicated**~~, requiring~~ **use of** ~~rituximab monotherapy to be used; and~~

8 ~~9~~ Maximum of two ~~1,000~~ **1000** mg infusions ~~of rituximab~~ given two weeks apart.

Initial application – (**arthritis** - rheumatoid ~~arthritis~~ - prior TNF inhibitor use) from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

~~1 Both:~~

1 ~~1.1 The p~~**P**atient has had a~~n initial community~~ Special Authority approval for ~~at least one of~~ etanercept ~~and/~~or adalimumab for rheumatoid arthritis; and

2 ~~1.2~~ Either:

2.1 ~~1.2.1 The p~~**P**atient has experienced intolerable side effects ~~from a reasonable trial of adalimumab and/or etanercept~~; or

2.2 ~~1.2.2~~ Following at least a ~~four~~**4** month trial of adalimumab ~~and/~~or etanercept, ~~the patient did not meet~~ the renewal criteria ~~for adalimumab and/or etanercept~~ for rheumatoid arthritis **were not met;** and

continued...

Changes to Restrictions – effective 1 March 2026 (continued)

continued...

~~2 Either:~~
~~2.1 Rituximab to be used as an adjunct to methotrexate or leflunomide therapy; or~~
~~2.2 Patient is contraindicated to both m~~ **M**ethotrexate and leflunomide ~~**are contraindicated**, requiring rituximab monotherapy to be used.; and~~
3 Maximum of two ~~1,000~~ **1000** mg infusions ~~of rituximab~~ given two weeks apart.

Renewal – (**arthritis -** rheumatoid ~~arthritis~~ – retreatment ~~in 'partial responders"~~ **for people who have experienced a partial response** to rituximab) from any relevant practitioner. Approvals valid for ~~4 months~~ **12 months** for applications meeting the following criteria:
All of the following:
1 Any of the following:
1.1 ~~At 4 months f~~**F**ollowing the initial course of rituximab ~~infusions~~ the patient ~~had~~ **experienced** between a 30% and 50% decrease in active joint count from baseline ~~and a clinically significant response to treatment in the opinion of the physician~~; or
1.2 ~~At 4 months f~~**F**ollowing the second course of rituximab ~~infusions~~ the patient ~~had~~ **experienced** 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
1.3 ~~At 4 months f~~**F**ollowing the third and subsequent courses of rituximab ~~infusions~~, the patient ~~demonstrates~~ **experienced** 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
2 Rituximab re-treatment not to be given within 6 months of the previous course of treatment; and
~~3 Either:~~
~~3.1 Rituximab to be used as an adjunct to methotrexate or leflunomide therapy; or~~
~~3.2 Patient is contraindicated to both methotrexate and leflunomide, requiring rituximab monotherapy. to be used.; and~~
3 ~~4~~ Maximum of two ~~1,000~~ **1000** mg infusions ~~of rituximab~~ given two weeks apart.

Renewal – (**arthritis** - rheumatoid ~~arthritis~~ – retreatment ~~in~~ **for people who experience a response** ~~'responders'~~ to rituximab) from any relevant practitioner. Approvals valid for ~~4 months~~ **12 months** for applications meeting the following criteria:
All of the following:
1 Either:
1.1 ~~At 4 months f~~**F**ollowing the initial course of rituximab infusions the patient ~~had~~ **experienced** 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
1.2 ~~At 4 months f~~**F**ollowing the second and subsequent courses of rituximab ~~infusions~~, the patient ~~demonstrates~~ **experienced** 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
2 Rituximab re-treatment not to be given within 6 months of the previous course of treatment; and
~~3 Either:~~
~~3.1 Rituximab to be used as an adjunct to methotrexate or leflunomide therapy; or~~
~~3.2 Patient is contraindicated to both methotrexate and leflunomide, requiring rituximab monotherapy to be used; and~~
3 ~~4~~ Maximum of two ~~1,000~~ **1000** mg infusions ~~of rituximab~~ **per course** given two weeks apart.

Changes to Restrictions – effective 1 March 2026 (continued)

225 RITUXIMAB (RIXIMYO) – PCT only – Specialist – Special Authority see **SA2623** ~~2497~~ (amended Special Authority criteria – affected criteria shown only)

Inj 100 mg per 10 ml vial	275.33	2	✔**Riximyo**
Inj 500 mg per 50 ml vial	688.20	1	✔**Riximyo**
Inj 1 mg for ECP	1.38	1 mg	✔**Baxter (Riximyo)**

➽ **SA2623** ~~2497~~ Special Authority for Subsidy

Initial application – (~~N~~**n**euromyelitis ~~O~~**o**ptica ~~S~~**s**pectrum ~~D~~**d**isorder (NMOSD)*****) ~~only~~ from **any relevant practitioner** ~~a relevant specialist or medical practitioner on the recommendation of a relevant specialist~~. Approvals valid **without further renewal unless notified** ~~for 6 months~~ for applications meeting the following criteria:

~~Both~~ **All of the following**:

1 ~~One of the following dose regimens is to be used: 2 doses of 1,000 mg rituximab administered fortnightly, or 4 doses of 375 mg/m² administered weekly for four weeks~~ **Cumulative dose up to 1,500 mg/m² body surface area up to 2,000 mg total per cycle; and**

2 Either

2.1 ~~The p~~**P**atient has experienced a severe episode or attack of NMOSD (rapidly progressing symptoms ~~and~~ **with supporting** ~~supportive~~ clinical investigations ~~supportive of a severe attack of NMOSD~~); or

2.2 All of the following:

2.2.1 ~~The p~~**P**atient has experienced a breakthrough attack of NMOSD; and

2.2.2 ~~The p~~**P**atient is receiving treatment with mycophenolate **unless contraindicated or not tolerated**; and

2.2.3 ~~The p~~**P**atient is receiving treatment with corticosteroids **unless contraindicated or not tolerated; and**

3 Each treatment cycle at least 6 months apart.

Note: Indications marked with * are unapproved indications.

~~Renewal – Neuromyelitis Optica Spectrum Disorder (NMOSD) 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:~~

~~All of the following:~~

~~1 One of the following dose regimens is to be used: 2 doses of 1,000 mg rituximab administered fortnightly, or 4 doses of 375 mg/m² administered weekly for four weeks; and~~

~~2 The patient has responded to the most recent course of rituximab; and~~

~~3 The patient has not received rituximab in the previous 6 months.~~

Initial application – (~~Severe~~ **R**~~r~~efractory ~~M~~**m**yasthenia ~~G~~**g**ravis*****) ~~only~~ from ~~a neurologist or medical~~ **any relevant** practitioner ~~on the recommendation of a neurologist~~. Approvals valid for 2 years for applications meeting the following criteria:

Both:

1 ~~One of the following dose regimens is to be used: 375 mg/m² of body surface area per week for a total of four weeks, or 500 mg once weekly for four weeks, or two 1,000 mg doses given two weeks apart; and~~ **Cumulative dose up to 1,500 mg/m² body surface area up to 2,000 mg total per cycle; and**

2 Either

2.1 Treatment with corticosteroids and at least one other immunosuppressant for ~~at least~~ a **minimum** period of 12 months has been ineffective; or

2.2 Both:

2.2.1 Treatment with at least one other immunosuppressant for a period of at least 12 months; and

2.2.2 Corticosteroids have been trialled for at least 12 months and have been discontinued due to unacceptable side effects.

Note: Indications marked with * are unapproved indications.

Renewal – (~~Severe~~ **R**~~r~~efractory ~~M~~**m**yasthenia ~~G~~**g**ravis*****) ~~only~~ from ~~a neurologist or~~ **any relevant** ~~medical~~ practitioner ~~on the recommendation of a neurologist~~. Approvals valid for 2 years for applications meeting the following criteria:

All of the following:

1 ~~One of the following dose regimens is to be used: 375 mg/m² of body surface area per week for a total of four weeks, or 500 mg once weekly for four weeks, or two 1,000 mg doses given two weeks apart; and~~ **Cumulative dose up to 1,500 mg/m² body surface area up to 2,000 mg total per cycle**; and

2 An initial response lasting at least 12 months was demonstrated; and

continued...

Changes to Restrictions – effective 1 March 2026 (continued)

continued...

3 Either:
  3.1 ~~The p~~**P**atient has relapsed despite treatment with corticosteroids and at least one other immunosuppressant for a period of at least 12 months; or
  3.2 Both:
    3.2.1 ~~The p~~**P**atient'**s** myasthenia gravis has relapsed despite treatment with at least one immunosuppressant for a period of at least 12 months; and
    3.2.2 Corticosteroids have been trialled for at least 12 months and have been discontinued due to unacceptable side effects.

Note: Indications marked with * are unapproved indications.

Initial application – (Steroid dependent nephrotic syndrome (SDNS) or frequently relapsing nephrotic syndrome (FRNS)) ~~only~~ from ~~a nephrologist or~~ **any relevant** ~~P~~**p**ractitioner ~~on the recommendation of a nephrologist~~. Approvals valid for 8 weeks for applications meeting the following criteria:
All of the following:
1 Patient is a child with SDNS* or FRNS*; and
2 Treatment with **cortico**steroids, **ciclosporin, and mycophenolate** for at least ~~a period of~~ 3 months **for each agent** has been ineffective, **not tolerated, or is contraindicated** ~~or associated with evidence of steroid toxicity~~; and
~~3 Treatment with ciclosporin for at least a period of 3 months has been ineffective and/or discontinued due to unacceptable side effects; and~~
~~4 Treatment with mycophenolate for at least a period of 3 months with no reduction in disease relapses; and~~
3 ~~5~~ The total rituximab dose used would not exceed the equivalent of 375 mg/m^2 of body surface area per week for a total of 4 weeks**.**
Note: Indications marked with * are unapproved indications.

Renewal – (Steroid dependent nephrotic syndrome (SDNS) or frequently relapsing nephrotic syndrome (FRNS)) ~~only~~ from ~~a nephrologist or~~ **any relevant** ~~P~~**p**ractitioner ~~on the recommendation of a nephrologist~~. Approvals valid for 8 weeks for applications meeting the following criteria:
All of the following:
1 Patient who was previously treated with rituximab for nephrotic syndrome*; and
2 Treatment with rituximab was previously successful and has demonstrated sustained response for greater than 6 months, but the condition has relapsed and the patient now requires repeat treatment; and
3 The total rituximab dose used would not exceed the equivalent of 375 mg/m^2 of body surface area per week for a total of 4 weeks.
Note: Indications marked with * are unapproved indications.

Initial application – (Steroid resistant nephrotic syndrome (SRNS)*****) ~~only~~ from ~~a nephrologist or~~ **any relevant** ~~P~~**p**ractitioner ~~on the recommendation of a nephrologist~~. Approvals valid for 8 weeks for applications meeting the following criteria:
All of the following:
1 Patient is a child with SRNS* ~~where~~ **and** treatment with **cortico**steroids**,** ~~and~~ ciclosporin **and tacrolimus** for at least 3 months **for each agent** ~~have~~ **has** been ineffective**, not tolerated, or is contraindicated**; and
~~3 Treatment with tacrolimus for at least 3 months has been ineffective; and~~
2 ~~3~~ Genetic causes of nephrotic syndrome have been excluded; and
3 ~~4~~ The total rituximab dose ~~used~~ **per cycle** would not exceed the equivalent of 375 mg/m^2 of body surface area per week for a total of 4 weeks**.**
Note: Indications marked with * are unapproved indications.

Renewal – (Steroid resistant nephrotic syndrome (SRNS)*****) only from a nephrologist or Practitioner on the recommendation of a nephrologist. Approvals valid for 8 weeks for applications meeting the following criteria:
All of the following:
1 Patient who was previously treated with rituximab for nephrotic syndrome*; and
2 Treatment with rituximab was previously successful and has demonstrated sustained response for greater than 6 months, but the condition has relapsed and the patient now requires repeat treatment; and
3 The total rituximab dose used would not exceed the equivalent of 375 mg/m^2 of body surface area per week for a total of 4 weeks.

continued...

Changes to Restrictions – effective 1 March 2026 (continued)

continued...

Note: Indications marked with * are unapproved indications.

Initial application – (thrombotic thrombocytopenic purpura (TTP)*****) only from a haematologist or **any relevant** ~~P~~**p**ractitioner on the recommendation of a haematologist. Approvals valid ~~for~~ **without further renewal unless notified** ~~8 weeks~~ for applications meeting the following criteria:

~~Both~~ **All of the following**:

1 The total rituximab dose ~~used~~ **per cycle** would not exceed the equivalent of 375 mg/m^2 **of** body surface area per week for a total of 4 weeks**; and**

2 Each treatment cycle at least 6 months apart; and

3 Either:

3.1 Patient has ~~thrombotic thrombocytopenic purpura* and has~~ experienced progression of clinical symptoms or persistent thrombocytopenia despite plasma exchange; or

3.2 Patient has acute idiopathic ~~thrombotic thrombocytopenic purpura~~**TTP*** with neurological or cardiovascular pathology.

Note: Indications marked with * are unapproved indications.

~~Renewal – (thrombotic thrombocytopenic purpura (TTP)) only from a haematologist or Practitioner on the recommendation of a haematologist. Approvals valid for 8 weeks for applications meeting the following criteria.~~
~~All of the following:~~
~~1 Patient was previously treated with rituximab for thrombotic thrombocytopenic purpura*; and~~
~~2 An initial response lasting at least 12 months was demonstrated; and~~
~~3 Patient now requires repeat treatment; and~~
~~4 The total rituximab dose used would not exceed the equivalent of 375 mg/m^2 of body surface area per week for a total of 4 weeks~~
~~Note: Indications marked with * are unapproved indications.~~

Initial application – (treatment refractory systemic lupus erythematosus (SLE)*****) only from a rheumatologist, nephrologist or **any relevant** ~~P~~**p**ractitioner on the recommendation of a rheumatologist or nephrologist. Approvals valid **without further renewal unless notified** ~~for 7 months~~ for applications meeting the following criteria:

All of the following:

1 ~~The p~~**P**atient has severe, immediately life- or organ-threatening SLE*; and

2 The ~~disease~~ **condition** has **been** ~~proved~~ refractory to treatment with **cortico**steroids at a dose of at least 1 mg/kg **unless contraindicated**; and

3 The ~~disease~~ **condition** has relapsed following prior treatment for at least 6 months with maximal tolerated doses of azathioprine, mycophenolate mofetil**,** and high dose cyclophosphamide, or cyclophosphamide is contraindicated; and

4 **Initial treatment** ~~M~~**m**aximum of four 1000 mg infusions ~~of rituximab~~**; and**

5 Treatment for relapse following initial partial response to rituximab up to a maximum of two 1000 mg infusions every 6 months.

Note: Indications marked with * are unapproved indications.

~~Renewal – (treatment refractory systemic lupus erythematosus (SLE)) only from a rheumatologist, nephrologist, or Practitioner on the recommendation of a rheumatologist or nephrologist. Approvals valid for 6 months for applications meeting the following criteria.~~
~~All of the following:~~
~~1 Patient's SLE* achieved at least a partial response was achieved from to the previous round of prior rituximab treatment; and~~
~~2 The disease has subsequently relapsed.; and~~
~~3 Maximum of two 1000 mg infusions of rituximab~~
~~Note: Indications marked with * are unapproved indications.~~

Initial application – (~~severe~~ antisynthetase syndrome) from any relevant practitioner. Approvals valid ~~for~~ **without further renewal unless notified** ~~12 months~~ for applications meeting the following criteria.

All of the following**:**

~~1 Patient has confirmed antisynthetase syndrome; and~~

1 ~~2~~ Patient has severe, immediately life**-** or organ**-**threatening disease, including interstitial lung disease; and

continued...

Changes to Restrictions – effective 1 March 2026 (continued)

continued...

2 ~~3~~ Either:

2.1 ~~3.1~~ Treatment with at least 3 immunosuppressants (oral **cortico**steroids, cyclophosphamide, methotrexate, mycophenolate, ciclosporin, azathioprine) has ~~not be~~ **been in**effective ~~at~~ controlling active disease; or

2.2 ~~3.2~~ Rapid treatment is required ~~due to~~ **for** life threatening complications.~~; and~~

3 ~~4~~ Maximum of ~~four~~ **two** ~~1,000~~**1000** mg infusions ~~of rituximab~~ **every 6 months**.

~~Renewal – (severe antisynthetase syndrome) from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria.~~

~~All of the following:~~

~~1 Patient's disease has responded to the previous rituximab treatment with demonstrated improvement in inflammatory markers, muscle strength, and pulmonary function; and~~

~~2 The patient has not received rituximab in the previous 6 months.; and~~

~~3 Maximum of two cycles of 2 × 1,000mg infusions of rituximab given two weeks apart~~

Initial application – (~~severe~~ chronic inflammatory demyelinating polyneuropathy **(CIPD)*)** only from a neurologist or **any relevant** ~~medical~~ practitioner on the recommendation of a neurologist. Approvals valid **without further renewal unless notified** ~~for 6 months~~ for applications meeting the following criteria.

All of the following:

~~1 Patient has severe chronic inflammatory demyelinating polyneuropathy (CIPD); and~~

1 ~~2~~ Either:

~~2.~~1.1 Both:

~~2.~~1.1.1 Treatment with **cortico**steroids and intravenous immunoglobulin and/or plasma exchange has ~~not~~ been **in**effective ~~at~~ controlling active disease**, is not tolerated, or is contraindicated**; and

~~2.~~1.1.2 At least one other immunosuppressant (cyclophosphamide, ciclosporin, tacrolimus, mycophenolate) **is not tolerated or** has ~~not~~ been **in**effective ~~at~~ controlling active disease. **If an immunosuppressant is contraindicated, a trial has occurred of one of those which is not contraindicated (unless all are contraindicated);** or

~~2.~~1.2 Rapid treatment is required ~~due to~~ **for** life threatening complications; and

2 ~~One of the following dose regimens is to be used: 375 mg/m² of body surface area per week for a total of four weeks, or 500 mg once weekly for four weeks, or two 1,000 mg doses given two weeks apart~~. **Cumulative dose up to 1500 mg/m² body surface area up to 2000 mg total per cycle; and**

3 Each treatment cycle at least 6 months apart.

Note: Indications marked with * are unapproved indications

~~Renewal – (severe chronic inflammatory demyelinating polyneuropathy) only from a neurologist or any medical practitioner on the recommendation of a neurologist Approvals valid for 6 months for applications meeting the following criteria.~~

~~All of the following:~~

~~1 Patient's disease has responded to the previous rituximab treatment with demonstrated improvement in neurological function compared to baseline; and~~

~~2 The patient has not received rituximab in the previous 6 months; and~~

~~3 One of the following dose regimens is to be used: 375 mg/m² of body surface area per week for a total of four weeks, or 500 mg once weekly for four weeks, or two 1,000 mg doses given two weeks apart.~~

Initial application – (anti-NMDA receptor autoimmune encephalitis*) ~~only~~ from ~~a neurologist or~~ any **relevant** ~~medical~~ practitioner ~~on the recommendation of a neurologist~~. Approvals valid **without further renewal unless notified** ~~for 6 months~~ for applications meeting the following criteria.

All of the following:

~~Patient has severe anti-NMDA receptor autoimmune encephalitis; and~~

2 **1** Either:

~~2.~~1.1 Both:

~~2.~~1.1.1 Treatment with **cortico**steroids and intravenous immunoglobulin and/or plasma exchange ~~has not been effective at controlling~~ **has been ineffective controlling** active disease, **is not tolerated or is contraindicated**; and

~~2.~~1.1.2 At least one other immunosuppressant (cyclophosphamide, ciclosporin, tacrolimus,

continued...

Changes to Restrictions – effective 1 March 2026 (continued)

continued...

mycophenolate) ~~has not been effective at controlling~~ **has been ineffective controlling** active disease, **is not tolerated or is contraindicated**; or

~~2.~~1.2 Rapid treatment is required ~~due to~~ **for** life threatening complications; and

2 ~~One of the following dose regimens is to be used 375 mg/m² of body surface area per week for a total of four weeks, or 500 mg once weekly for four weeks, or two 1,000mg doses given two weeks apart~~ **Cumulative dose up to 1500 mg/m² body surface area up to 2000 mg total per cycle; and**

3 Each treatment cycle at least 6 months apart.

Note: Indications marked with * are unapproved indications.

~~Renewal – (anti-NMDA receptor autoimmune encephalitis) only from a neurologist or any medical practitioner on the recommendation of a neurologist. Approvals valid for 6 months for applications meeting the following criteria.~~

~~All of the following:~~

~~1 Patient's disease has responded to the previous rituximab treatment with demonstrated improvement in neurological function; and~~

~~2 The patient has not received rituximab in the previous 6 months; and~~

~~3 The patient has experienced a relapse and now requires further treatment; and~~

~~4 One of the following dose regimens is to be used: 375 mg/m² of body surface area per week for a total of four weeks, or 500 mg once weekly for four weeks, or two 1,000 mg doses given two weeks apart.~~

Initial application – (~~M~~**m**embranous nephropathy) ~~only~~ from ~~a nephrologist or~~ any relevant practitioner ~~on the recommendation of a nephrologist~~. Approvals valid **without further renewal unless notified** ~~for 6 weeks~~ for applications meeting the following criteria.

All of the following**:**

1 Either:

1.1 Patient has biopsy-proven primary/idiopathic membranous nephropathy*****; or

1.2 Patient has PLA2 antibodies with no evidence of secondary cause, and an eGFR of >60 ml/min/1.73m²; and

2 Patient remains at high risk of progression to end-stage kidney disease despite more than 3 months of treatment with conservative measures ~~(see Note)~~ **that include (unless contraindicated or the patient has experienced intolerable side effects) renin-angiotensin system blockade, blood-pressure management, dietary sodium and protein restriction, treatment of dyslipidaemia, and anticoagulation agents;** and

3 The total rituximab dose **per cycle** would not exceed the equivalent of 375mg/m² of body surface area per week for a total of 4 weeks**; and**

4 Subsequent retreatment only for disease relapse or after partial response.

Note: Indications marked with * are unapproved indications.

~~Renewal – (Membranous nephropathy) only from a nephrologist or any relevant practitioner on the recommendation of a nephrologist. Approvals valid for 6 weeks for applications meeting the following criteria.~~

~~All of the following:~~

~~1 Patient was previously treated with rituximab for membranous nephropathy*; and~~

~~2 Either:~~

~~2.1 Treatment with rituximab was previously successful, but the condition has relapsed, and the patient now requires repeat treatment; or~~

~~2.2 Patient achieved partial response to treatment and requires repeat treatment (see Note); and~~

~~3 The total rituximab dose used would not exceed the equivalent of 375 mg/m² of body surface area per week for a total of 4 weeks~~

~~Note:~~

~~a) Indications marked with * are unapproved indications.~~

~~b) High risk of progression to end-stage kidney disease defined as >5 g/day proteinuria.~~

~~c) Conservative measures include renin-angiotensin system blockade, blood-pressure management, dietary sodium and protein restriction, treatment of dyslipidaemia, and anticoagulation agents unless contraindicated or the patient has experienced intolerable side effects.~~

~~d) Partial response defined as a reduction of proteinuria of at least 50% from baseline, and between 0.3 grams and 3.5 grams per 24 hours.~~

Changes to Restrictions – effective 1 March 2026 (continued)

236 SECUKINUMAB – Special Authority see **SA2624** ~~2488~~ – Retail pharmacy (amended Special Authority criteria – affected criteria shown only)

Inj 150 mg per ml, 1 ml prefilled syringe	799.50	1	✔**Cosentyx**
	1,599.00	2	✔**Cosentyx**

➽ **SA2624** ~~2488~~ Special Authority for Subsidy

~~Initial application – (severe chronic plaque psoriasis – second-line biologic) only from a dermatologist or any relevant practitioner on the recommendation of 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 Health NZ Hospital, 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 DQLI 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 or any relevant practitioner on the recommendation of a dermatologist. Approvals valid for 4 months for applications meeting the following criteria:~~

~~All of the following:~~

~~1 Any of the following:~~

~~1.1 Patient has "whole body" severe chronic plaque psoriasis with a Psoriasis Area and Severity Index (PASI) score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis; or~~

~~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; or~~

~~1.3 Patient has severe chronic localised genital or flexural plaque psoriasis where the plaques or lesions have been present for at least 6 months from the time of initial diagnosis, and with a Dermatology Life Quality Index (DLQI) score greater than 10; 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 DQLI 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. foot, genital or flexural areas, at least 2 of the 3 PASI symptom sub scores for erythema, thickness and scaling are rated as severe or very severe, and for the face, palm of a hand or sole of a foot 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 – (plaque psoriasis) from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Either:

1 All of the following:

1.1 Any of the following:

1.1.1 Patient has "whole body" plaque psoriasis with a PASI score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis; or

continued...

Changes to Restrictions – effective 1 March 2026 (continued)

continued...

1.1.2 Patient has 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; or

1.1.3 Patient has localised genital or flexural plaque psoriasis where the plaques or lesions have been present for at least 6 months from the time of initial diagnosis, and with a DLQI score greater than 10; and

1.2 Patient has received insufficient benefit (see Note) or has experienced intolerable side effects from at least 3 of the following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, ciclosporin, or acitretin; and

1.3 A PASI assessment or DLQI assessment has been completed for the most recent prior treatment course, within 1 month of stopping that treatment; and

1.4 The most recent PASI or DQLI assessment is within 1 month before the application; or

2 All of the following:

2.1 Patient has had a Special Authority approval for adalimumab, etanercept, or infliximab, for plaque psoriasis; and

2.2 Either:

2.2.1 Patient has experienced intolerable side effects; or

2.2.2 Patient has received insufficient benefit to meet the renewal criteria for plaque psoriasis; and

2.3 A PASI assessment or DLQI assessment has been completed for the most recent prior treatment within 1 month of stopping that treatment; and

2.4 The most recent PASI or DQLI assessment is within 1 month before the application.

Note: A treatment course is defined as a minimum of 12 weeks of treatment. "Insufficient benefit" is defined as: for whole body plaque psoriasis, a PASI score of greater than 10; for plaque psoriasis of the face, hand, foot, genital or flexural areas, at least 2 of the 3 PASI symptom sub scores for erythema, thickness and scaling are rated as severe or very severe, and for the face, palm of a hand or sole of a foot 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~~) from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:
Both:

1 Any of the following:
- 1.1 Patient's PASI score has reduced by 75% or more ~~(PASI 75) as~~ compared to **pre-secukinumab** 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 **pre-secukinumab** baseline ~~DLQI prior to commencing secukinumab~~; or
- 1.3 Both:
  - 1.3.1 Patient had ~~severe chronic~~ localised genital or flexural plaque psoriasis at the start of treatment; and
  - 1.3.2 Either:
    - 1.3.2.1 Patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, ~~as~~ compared to the pre-**secukinumab** ~~treatment~~ baseline ~~value~~; or
    - 1.3.2.2 Patient has a ~~Dermatology Quality of Life Index (~~DLQI~~)~~ improvement of 5 or more, ~~as~~ compared to **pre-secukinumab** baseline ~~DLQI prior to commencing secukinumab~~; and

2 ~~Secukinumab to be administered at a~~ **M**aximum dose ~~of~~ 300 mg monthly.

Initial application – (ankylosing spondylitis – second-line biologic) ~~only~~ from ~~a rheumatologist or~~ **any relevant p**Practitioner ~~on the recommendation of a rheumatologist~~. Approvals valid for 3 months for applications meeting the following criteria:
Both:

1 ~~The p~~**P**atient has had a~~n initial~~ Special Authority approval for adalimumab ~~and~~/or etanercept for ankylosing spondylitis; and

2 Either:
- 2.1 ~~The p~~**P**atient has experienced intolerable side effects ~~from a reasonable trial of adalimumab and/or etanercept~~; or
- 2.2 ~~Following 12 weeks of adalimumab and/or etanercept treatment, the p~~**P**atient **has received insufficient benefit to** ~~did not~~ meet the renewal criteria for ~~adalimumab and/or etanercept for~~ ankylosing spondylitis.

continued...

Changes to Restrictions – effective 1 March 2026 (continued)

continued...

Renewal – (ankylosing spondylitis – second-line biologic) ~~only~~ from **any relevant practitioner** ~~a rheumatologist or medical practitioner on the recommendation of a rheumatologist.~~ Approvals valid for 6 months for applications meeting the following criteria:

~~All of the following~~ **Both:**

1 ~~Following 12 weeks initial treatment of secukinumab treatment,~~ BASDAI has improved ~~by 4 or more points~~ from **the** pre-secukinumab baseline **either by at least 4 points** on a ~~10 point~~ **10-point** scale, or by **at least** 50%, whichever is less; and

~~2 Physician considers that the patient has benefitted from treatment and that continued treatment is appropriate; and~~

2 ~~3 Secukinumab to be administered at doses no greater than~~ **Maximum dose** 300 mg monthly.

Initial application – (**arthritis** - psoriatic ~~arthritis~~) ~~only~~ from ~~a rheumatologist or~~ **any relevant practitioner**. Approvals valid for 6 months for applications meeting the following criteria:

Either:

1 Both:
  1.1 Patient has had ~~an initial~~ Special Authority approval for adalimumab, etanercept or infliximab for psoriatic arthritis; and
  1.2 Either:
    1.2.1 Patient has experienced intolerable side effects ~~from adalimumab, etanercept or infliximab~~; or
    1.2.2 Patient has received insufficient benefit ~~from adalimumab, etanercept or infliximab~~ to meet the renewal criteria ~~for adalimumab, etanercept or infliximab~~ 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~~
  2.1 ~~2.2~~ Patient has ~~tried and not responded to~~ **received insufficient benefit from** at least ~~three~~ **3** months of ~~oral or parenteral~~ methotrexate at a ~~dose of at least 20 mg weekly or a~~ maximum tolerated dose **unless contraindicated**; and
  2.2 ~~2.3~~ Patient has ~~tried and not responded to~~ **received insufficient benefit from** at least ~~three~~ **3** 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~~)~~ **unless contraindicated**; and
  2.3 ~~2.4~~ Either:
    2.3.1 ~~2.4.1~~ Patient has persistent symptoms of poorly controlled and active disease in at least 15 ~~swollen, tender~~ joints; or
    2.3.2 ~~2.4.2~~ Patient has persistent symptoms of poorly controlled and active disease in at least ~~four~~ **4** joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip; and
  2.4 ~~2.5~~ Any of the following:
    2.4.1 ~~2.5.1 Patient has a C-reactive protein~~ **CRP** ~~level~~ greater than 15 mg/L measured ~~no more than~~ **within** one month ~~prior to the date of this~~ **before the** application; or
    2.4.2 ~~2.5.2 Patient has an elevated erythrocyte sedimentation rate (~~ESR~~)~~ greater than 25 mm per hour **measured within one month before the application**; or
    2.4.3 ~~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~~ **received** for more than ~~three~~ **3** months.

Renewal – (**arthritis** - psoriatic ~~arthritis~~) ~~only~~ from **any relevant practitioner** ~~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 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
  1.2 ~~The patient~~ ~~demonstrates~~ At least a continuing 30% improvement in active joint count from baseline ~~and a clinically significant response to prior secukinumab treatment in the opinion of the treating physician~~; and

2 ~~Secukinumab to be administered at doses no greater than~~ **Maximum dose** 300 mg monthly.

		Subsidy (Mnfr's price) $	Per	Brand or Generic Mnfr ✔ fully subsidised

Changes to Subsidy and Manufacturer's Price

Effective 1 March 2026

42	HEPARIN SODIUM (↑ subsidy)			
	Inj 1,000 iu per ml, 5 ml ampoule	164.40	50	✔**Pfizer**
49	CARVEDILOL (↓ subsidy)			
	✳ Tab 6.25 mg	1.97	60	✔**Carvedilol Sandoz**
	✳ Tab 12.5 mg	2.03	60	✔**Carvedilol Sandoz**
	✳ Tab 25 mg	2.46	60	✔**Carvedilol Sandoz**
56	ADRENALINE (↑ subsidy)			
	Inj 1 in 1,000, 1 ml ampoule			
	– Up to 5 inj available on a PSO	17.78	5	✔**DBL Adrenaline**
	1) Note: adrenaline inj 1 in 1,000, 1 ml ampoule can be supplied on BSO to a Vaccinator (other than a Pharmacist) under the provisions in Part I of Section A			
	2) Note: Direct Provision by a pharmacist of Inj 1 in 1,000, 1 ml ampoule permitted under the provisions in Part I of Section A.			
	Inj 1 in 10,000, 10 ml ampoule			
	– Up to 5 inj available on a PSO	36.18	5	✔**Hospira**
79	ETHINYLOESTRADIOL WITH NORETHISTERONE (↑ subsidy)			
	Tab 35 mcg with norethisterone 1 mg and 7 inert tab			
	– Up to 84 tab available on a PSO	14.09	84	✔**Brevinor 1/28**
	Tab 35 mcg with norethisterone 500 mcg and 7 inert tab			
	– Up to 112 tab available on a PSO	23.75	84	✔**Norimin**
80	NORETHISTERONE (↑ subsidy)			
	Tab 350 mcg – Up to 84 tab available on a PSO	13.23	84	✔**Noriday 28**
85	TESTOSTERONE CIPIONATE (↑ subsidy)			
	Inj 100 mg per ml, 10 ml vial	97.75	1	✔**Depo-Testosterone**
86	MEDROXYPROGESTERONE ACETATE (↑ subsidy)			
	✳ Tab 2.5 mg	7.54	30	✔**Provera**
	✳ Tab 5 mg	23.15	100	✔**Provera**
	✳ Tab 10 mg	11.10	30	✔**Provera**
87	MEDROXYPROGESTERONE ACETATE (↑ subsidy)			
	Tab 100 mg	153.60	100	✔**Provera HD**
98	GENTAMICIN SULPHATE (↑ subsidy)			
	Inj 10 mg per ml, 1 ml ampoule			
	– Subsidy by endorsement	102.60	5	✔**DBL Gentamicin**
	Only if prescribed for a dialysis or cystic fibrosis patient or complicated urinary tract infection and the prescription is endorsed accordingly.			
135	HALOPERIDOL – Safety medicine; prescriber may determine dispensing frequency (↓ subsidy)			
	Inj 5 mg per ml, 1 ml ampoule			
	– Up to 5 inj available on a PSO	12.93	10	✔**Serenace**

Check your Schedule for full details Schedule page ref	Subsidy (Mnfr's price) $	Per	Brand or Generic Mnfr ✔ **fully subsidised**

Changes to Subsidy and Manufacturer's Price – effective 1 March 2026 (continued)

142 MIDAZOLAM – Safety medicine; prescriber may determine dispensing frequency (↑ subsidy)

Inj 1 mg per ml, 5 ml plastic ampoule

– Up to 10 inj available on a PSO ..... 46.65 10 ✔ **Midazolam-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 plastic ampoule

– Up to 5 inj available on a PSO ..... 35.10 5 ✔ **Midazolam-Pfizer**

On a PSO for status epilepticus use only. PSO must be endorsed for status epilepticus use only.

157 DAUNORUBICIN – PCT only – Specialist (↓ subsidy)

Inj 18.7 mg for ECP ..... 160.75 18.7 mg OP ✔ **Baxter**

Inj 18.7 mg vial ..... 160.75 1 ✔ **Pfizer**

▲ 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 at one time

Check your Schedule for full details Schedule page ref	Subsidy (Mnfr's price) $	Per	Brand or Generic Mnfr ✔ **fully subsidised**

Delisted Items

Effective 1 March 2026

33 FERROUS SULFATE
Tab long-acting 325 mg (105 mg elemental) ... 2.55 | 30 | ✔Ferrograd
Note: No new patients to be initiated on ferrous sulfate

50 SOTALOL
✻ Tab 80 mg ... 22.50 | 300 | ✔Sotalol Viatris S29

84 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 ... 7.86 | 10 | ✔Hameln
✻ Inj 4 mg per ml, 2 ml ampoule
– Up to 5 inj available on a PSO ... 13.10 | 10 | ✔Hameln

98 CLINDAMYCIN
Inj 150 mg per ml, 4 ml ampoule ... 35.10 | 10 | ✔Hameln

100 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 ... 3.38 | 1 | ✔Mylan

128 NORTRIPTYLINE HYDROCHLORIDE – Safety medicine; prescriber may determine dispensing frequency
Tab 10 mg ... 2.46 | 100 | ✔Norpress
Tab 25 mg ... 6.29 | 180 | ✔Norpress

129 PAROXETINE
✻ Tab 20 mg ... 1.66 | 30 | ✔Paxtine

174 SUNITINIB – Special Authority see SA2452 – Retail pharmacy
Cap 12.5 mg ... 208.38 | 28 | ✔Sunitinib Pfizer
Cap 25 mg ... 416.77 | 28 | ✔Sunitinib Pfizer

276 CHLORAMPHENICOL
Eye drops 0.5% ... 1.45 | 10 ml OP | ✔Chlorsig
Funded for use in the ear*. Indications marked with * are unapproved indications.

281 PHARMACY SERVICES
✻ Brand switch fee ... 4.50 | 1 fee | ✔BSF Estradiol TDP Mylan
a) May only be claimed once per patient.
b) The Pharmacode for BSF Estradiol TDP Mylan is 2717573

288 FAT SUPPLEMENT – Special Authority see SA2204 – Hospital pharmacy [HP3]
Emulsion (neutral) ... 38.44 | 500 ml OP | ✔Calogen
Note – this delist applies to the 500 ml pack.

288 DIABETIC ORAL FEED 1KCAL/ML – Special Authority see SA1095 – Hospital pharmacy [HP3]
Liquid (vanilla), 200 ml bottle ... 2.10 | 1 OP | ✔Nutren Diabetes

Check your Schedule for full details Schedule page ref	Subsidy (Mnfr's price) $	Per	Brand or Generic Mnfr ✔ **fully subsidised**

Delisted Items – effective 1 March 2026 (continued)

291 ORAL ELEMENTAL FEED 1KCAL/ML – Special Authority see SA1377 – Hospital pharmacy [HP3]

Powder (unflavoured), 80 g sachet	4.50	1 OP	✔Vivonex TEN

294 ENTERAL FEED 1.5KCAL/ML – Special Authority see SA1859 – Hospital pharmacy [HP3]

Liquid, 250 ml can	2.17	1 OP	✔Ensure Plus HN

298 AMINOACID FORMULA WITHOUT METHIONINE – Special Authority see SA2357 – Hospital pharmacy [HP3]

Liquid (juicy berries), 125 ml bottle	1,684.80	30	✔HCU Lophlex LQ

Note – this delist applies to Pharmacode 2592096.

298 AMINOACID FORMULA WITHOUT VALINE, LEUCINE AND ISOLEUCINE – Special Authority see SA2357 – Hospital pharmacy [HP3]

Liquid (juicy berries) 125 ml pouches	1,684.80	30	✔MSUD Lophlex LQ 20

Note – this delist applies to Pharmacode 2683016.

315 INFLUENZA VACCINE

Inj 60 mcg in 0.5 ml syringe (quadrivalent vaccine)	120.00	10	✔Influvac Tetra (2025 formulation)

a) Maximum of 1 inj per prescription
b) Only on a prescription
c) No patient co-payment payable
d) Access criteria apply

Items to be Delisted

Effective 1 June 2026

~~151 VARENICLINE TARTRATE – Special Authority see SA1845 – Retail pharmacy~~
~~a) A maximum of 12 weeks' varenicline will be subsidised on each Special Authority approval, including the starter pack~~
~~b) Varenicline will not be funded in amounts less than 4 weeks of treatment.~~
~~c) The 6-month time period in which a patient can receive a funded 12-week course of varenicline tartrate starts from the date the Special Authority is approved.~~
~~Tab 0.5 mg × 11 and 1 mg × 42 ..... 16.67 53 OP ✔ Champix~~
~~Tab 1 mg ..... 17.62 56 ✔ Champix~~
Note – delisting delayed until 1 September 2026.

Effective 1 July 2026

281 PHARMACY SERVICES
✻ Brand switch fee ..... 4.50 1 fee ✔ **BSF Lyrica**
a) May only be claimed once per patient.
b) The Pharmacode for BSF Lyrica is 2723727.

Effective 1 August 2026

52 FUROSEMIDE [FRUSEMIDE]
✻ Inj 10 mg per ml, 2 ml ampoule
– Up to 10 inj available on a PSO ..... 2.40 5 ✔ **Furosemide-Baxter**

Effective 1 September 2026

151 VARENICLINE TARTRATE – Special Authority see SA1845 – Retail pharmacy
a) A maximum of 12 weeks' varenicline will be subsidised on each Special Authority approval, including the starter pack
b) Varenicline will not be funded in amounts less than 4 weeks of treatment.
c) The 6-month time period in which a patient can receive a funded 12-week course of varenicline tartrate starts from the date the Special Authority is approved.
Tab 0.5 mg × 11 and 1 mg × 42 ..... 16.67 53 OP ✔ **Champix**
Tab 1 mg ..... 17.62 56 ✔ **Champix**

Index
Pharmaceuticals and brands

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ISSN 1179-3686 (Online)

Te Kāwanatanga o Aotearoa New Zealand Government