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

PRESCRIBER

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Siltuximab

INITIATION
Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a haematologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Te Whatu Ora Hospital.

and

- ○ Patient has severe HHV-8 negative idiopathic multicentric Castleman's Disease

and

- ○ Treatment with an adequate trial of corticosteroids has proven ineffective

and

- ○ Siltuximab is to be administered at doses no greater than 11 mg/kg every 3 weeks

CONTINUATION
Re-assessment required after 12 months
Prerequisites (tick box where appropriate)

- ○ Prescribed by, or recommended by a haematologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Te Whatu Ora Hospital.

and

- ○ The treatment remains appropriate and the patient has sustained improvement in inflammatory markers and functional status

I confirm that the above details are correct:

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