

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:

Everolimus

INITIATION

Re-assessment required after 3 months

Prerequisites (tick boxes where appropriate)

- ☐ Prescribed by, or recommended by a neurologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ☐ Patient has tuberous sclerosis
- and
- ☐ Patient has progressively enlarging sub-ependymal giant cell astrocytomas (SEGAs) that require treatment

CONTINUATION

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

- ☐ Prescribed by, or recommended by a neurologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ☐ Documented evidence of SEGA reduction or stabilisation by MRI within the last 3 months
- and
- ☐ The treatment remains appropriate and the patient is benefiting from treatment
- and
- ☐ Everolimus to be discontinued at progression of SEGAs

I confirm that the above details are correct:

Signed: Date: