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: .....

## Nintedanib

**INITIATION – idiopathic pulmonary fibrosis**
Re-assessment required after 12 months
**Prerequisites** (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

**and**

- ○ Patient has been diagnosed with idiopathic pulmonary fibrosis by a multidisciplinary team including a radiologist

**and**

- ○ Forced vital capacity is between 50% and 90% predicted

**and**

- ○ Nintedanib is to be discontinued at disease progression (See Note)

**and**

- ○ Nintedanib is not to be used in combination with subsidised pirfenidone

**and**

- ○ The patient has not previously received treatment with pirfenidone

**or**

- ○ Patient has previously received pirfenidone, but discontinued pirfenidone within 12 weeks due to intolerance

**or**

- ○ Patient has previously received pirfenidone, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with pirfenidone)

**CONTINUATION – idiopathic pulmonary fibrosis**
Re-assessment required after 12 months
**Prerequisites** (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

**and**

- ○ Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment

**and**

- ○ Nintedanib is not to be used in combination with subsidised pirfenidone

**and**

- ○ Nintedanib is to be discontinued at disease progression (See Note)

Note: disease progression is defined as a decline in percent predicted FVC of 10% or more within any 12 month period.

HOSPITAL

I confirm that the above details are correct:

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