

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

PATIENT:

Name:

Name:

Ward:

NHI:

Ranibizumab

INITIATION – Wet Age Related Macular Degeneration

Re-assessment required after 3 months

Prerequisites (tick boxes where appropriate)

- Prescribed by, or recommended by an ophthalmologist or nurse practitioner, or in accordance with a protocol or guideline that has been endorsed by the Te Whatu Ora Hospital.

and

- Wet age-related macular degeneration (wet AMD)
or
 Polypoidal choroidal vasculopathy
or
 Choroidal neovascular membrane from causes other than wet AMD

and

- The patient has developed severe endophthalmitis or severe posterior uveitis following treatment with bevacizumab
or
 There is worsening of vision or failure of retina to dry despite three intraocular injections of bevacizumab four weeks apart

and

- There is no structural damage to the central fovea of the treated eye
and
 Patient has not previously been treated with aflibercept for longer than 3 months

- or
 Patient has current approval to use aflibercept for treatment of wAMD and was found to be intolerant to aflibercept within 3 months

CONTINUATION – Wet Age Related Macular Degeneration

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

- Prescribed by, or recommended by an ophthalmologist or nurse practitioner, or in accordance with a protocol or guideline that has been endorsed by the Te Whatu Ora Hospital.

and

- Documented benefit must be demonstrated to continue
and
 Patient's vision is 6/36 or better on the Snellen visual acuity score
and
 There is no structural damage to the central fovea of the treated eye

I confirm that the above details are correct:

Signed: Date: