HOSPITAL MEDICINES LIST
RESTRICTIONS CHECKLIST

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: .....

Aflibercept

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 Health NZ 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 ranibizumab for longer than 3 months

or

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

or

- ○ Patient has previously* (*before June 2018) received treatment with ranibizumab for wAMD and disease was stable while on treatment

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 Health NZ 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: .....

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: .....

Aflibercept *- continued*

INITIATION – Diabetic Macular Oedema
Re-assessment required after 4 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 Health NZ Hospital.

and

- ○ Patient has centre involving diabetic macular oedema (DMO)

and

- ○ Patient's disease is non responsive to 4 doses of intravitreal bevacizumab when administered 4-6 weekly

and

- ○ Patient has reduced visual acuity between 6/9 – 6/36 with functional awareness of reduction in vision

and

- ○ Patient has DMO within central OCT (ocular coherence tomography) subfield > 350 micrometers

and

- ○ There is no centre-involving sub-retinal fibrosis or foveal atrophy

CONTINUATION – Diabetic Macular Oedema
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 Health NZ Hospital.

and

- ○ There is stability or two lines of Snellen visual acuity gain

and

- ○ There is structural improvement on OCT scan (with reduction in intra-retinal cysts, central retinal thickness, and sub-retinal fluid)

and

- ○ Patient's vision is 6/36 or better on the Snellen visual acuity score

and

- ○ There is no centre-involving sub-retinal fibrosis or foveal atrophy

and

- ○ After each consecutive 12 months treatment with aflibercept, patient has retrialled with at least one injection of bevacizumab and had no response

I confirm that the above details are correct:

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