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 PATIENT	
Name: Name:	
Ward: NHI:	
Everolimus	
INITIATION Re-assessment required after 3 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a neurologist or oncologist, or in accordance Health NZ Hospital. and O Patient has tuberous sclerosis and O Patient has progressively enlarging sub-ependymal giant cell astrocytom	
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a neurologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by the	
and Health NZ Hospital. O Documented evidence of SEGA reduction or stabilisation by MRI within t and O The treatment remains appropriate and the patient is benefiting from treat and O Everolimus to be discontinued at progression of SEGAs	
INITIATION – renal cell carcinoma Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	
 The patient has metastatic renal cell carcinoma The disease is of predominant clear-cell histology The patient has documented disease progression following one preand The patient has an ECOG performance status of 0-2 The patient has an ECOG performance status of 0-2 Everolimus is to be used in combination with lenvatinib Patient has received funded treatment with nivolumab for the second Patient has experienced treatment limiting toxicity from treatment with and Everolimus is to be used in combination with lenvatinib 	nd line treatment of metastatic renal cell carcinoma
CONTINUATION – renal cell carcinoma Re-assessment required after 4 months Prerequisites (tick box where appropriate) O There is no evidence of disease progression	