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	PATIENT:	
Name:		
Ward:	NHI:	
Aflibercept		
INITIATION - Re-assessmen	Wet Age Related Macular Degeneration nt required after 3 months (tick boxes where appropriate)	
ar ar or	There is worsening of vision or failure of retina to dry despite three intraocular injections of bevacizumab four weeks apart There is no structural damage to the central fovea of the treated eye Patient has not previously been treated with ranibizumab or faricimab for longer than 3 months Patient has current approval to use ranibizumab or faricimab for treatment of wAMD and was found to be intolerant within 3 months	
Re-assessmer	ON – Wet Age Related Macular Degeneration ont required after 12 months (tick boxes where appropriate)	
O Documented benefit must be demonstrated to continue and O Patient's vision is 6/36 or better on the Snellen visual acuity score and O There is no structural damage to the central fovea of the treated eye		
Re-assessmer	Diabetic Macular Oedema nt required after 4 months (tick boxes where appropriate)	
O	Patient has centre involving diabetic macular oedema (DMO)	
	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	
and	Patient has not previously been treated with faricimab for longer than 3 months	

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:		
Aflibercept - continued			
CONTINUATION – Diabetic Macular Oedema Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) There is stability or two lines of Snellen visual acuity gain and There is structural improvement on OCT scan (with reduction i and Patient's vision is 6/36 or better on the Snellen visual acuity scand There is no centre-involving sub-retinal fibrosis or foveal atrophysics.			