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:		
Faricimab			
Re-assessmer	Diabetic macular oedema at required after 4 months (tick boxes where appropriate)		
Re-assessmer	Patient has centre involving diabetic macular oedema (DMO) Patient's disease is nonresponsive to 4 doses of intravitreal bevacizumab when administered 4-6 weekly Patient has reduced visual acuity between 6/9 - 6/36 with functional awareness of reduction in vision Patient has DMO within central OCT (ocular coherence tomography) subfield > 350 micrometers There is no centre-involving sub-retinal fibrosis or foveal atrophy Patient has not previously been treated with aflibercept for longer than 3 months DN - Diabetic macular oedema It required after 12 months (tick boxes where appropriate) There is stability or two lines of Snellen visual acuity gain There is structural improvement on OCT scan (with reduction in intra-retinal cysts, central retinal thickness, and sub-retinal fluid)		
and O	Patient's vision is 6/36 or better on the Snellen visual acuity score There is no centre-involving sub-retinal fibrosis or foveal atrophy		
INITIATION – Wet age related macular degeneration Re-assessment required after 3 months Prerequisites (tick boxes where appropriate)			
or	O Wet age-related macular degeneration (wet AMD) O Polypoidal choroidal vasculopathy O Choroidal neovascular membrane from causes other than wet AMD		
and	O The patient has developed severe endophthalmitis or severe posterior uveitis following treatment with bevacizumab O There is worsening of vision or failure of retina to dry despite three intraocular injections of bevacizumab four weeks apart		
and O	There is no structural damage to the central fovea of the treated eye Patient has not previously been treated with ranibizumab or aflibercept for longer than 3 months		

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PRESCRIBER		PATIENT:	
Name	<u>:</u>	Name:	
Ward:		NHI:	
Faricimab - continued CONTINUATION – Wet age related macular degeneration			
	ssessment required after 12 months		
Prerequisites (tick boxes where appropriate)			
	O Patient's vision is 6/36 or better on the Snellen visual acuity so	core	
	There is no structural damage to the central fovea of the treate	ed eye	