### Therapeutic Groups

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Alimentary Tract and Metabolism

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:
Calcium carbonate	

Prerequisites (tick box where appropriate)

O Only when prescribed for patients unable to swallow calcium carbonate tablets or where calcium carbonate tablets are inappropriate.

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:

### Budesonide

		Crohn's disease (tick boxes where appropriate)
an	O	Mild to moderate ileal, ileocaecal or proximal Crohn's disease
		O Diabetes
	or	O Cushingoid habitus
	or	O Osteoporosis where there is significant risk of fracture
	or	O Severe acne following treatment with conventional corticosteroid therapy
	or	O History of severe psychiatric problems associated with corticosteroid treatment
	or	O History of major mental illness (such as bipolar affective disorder) where the risk of conventional corticosteroid treatment causing relapse is considered to be high
	or	O Relapse during pregnancy (where conventional corticosteroids are considered to be contraindicated)
		Collagenous and lymphocytic colitis (microscopic colitis) (tick box where appropriate)
Ο	Patie	ent has a diagnosis of microscopic colitis (collagenous or lymphocytic colitis) by colonoscopy with biopsies
		Gut Graft versus Host disease (tick box where appropriate)
Ο	Patie	ent has gut Graft versus Host disease following allogenic bone marrow transplantation

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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.

PRES	CRIB	ER			PATIENT:
Name:					Name:
Ward:					NHI:
Bude	son	ide	- con	tinued	
Re-as	sess	men	it requi	rrhotic autoimmune hepatitis red after 6 months oxes where appropriate)	
	(	С	Patier	nt has autoimmune hepatitis*	
	and ( and	С	Patier	nt does not have cirrhosis	
			Ο	Diabetes	
		or or	0	Cushingoid habitus	
		or	Ο	Osteoporosis where there is significant risk of fracture	
			Ο	Severe acne following treatment with conventional cortic	osteroid therapy
		or	Ο	History of severe psychiatric problems associated with c	orticosteroid treatment
		or		History of major mental illness (such as bipolar affective causing relapse is considered to be high	disorder) where the risk of conventional corticosteroid treatment
		-	Ο	Relapse during pregnancy (where conventional corticost	eroids are considered to be contraindicated)
		or	Ο	Adolescents with poor linear growth (where conventional	corticosteroid use may limit further growth)
Note:	India	catio	ns ma	rked with * are unapproved indications.	
Re-as	sess	men	t requi	on-cirrhotic autoimmune hepatitis red after 6 months	
Prere	`			ox where appropriate)	
	ד ל	reatr	ment r	emains appropriate and the patient is benefitting from the	treatment

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.

PRES	CR	IBER	PATIENT:
Name	:		Name:
Ward:			NHI:
Rani	tid	ine	
INITI. Prere		ON isites (tick boxes where appropriate)	
	~	O For continuation use	
	or	O Routine prevention of allergic reactions.	
$\subseteq$			

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:
Omeprazole - Tab dispersible 10 mg and 20 mg	
INITIATION	
Prerequisites (tick box where appropriate)	
O Only for use in tube-fed patients	

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:
L-ornithine L-aspartate	

#### INITIATION

Prerequisites (tick box where appropriate)

()For patients with chronic hepatic encephalopathy who have not responded to treatment with, or are intolerant to lactulose, or where lactulose is contraindicated

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:
Rifaximin	
Prerequisites (tick box where appropriate)	

 $m O\,$  For patients with hepatic encephalopathy despite an adequate trial of maximum tolerated doses of lactulose

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:
Diazoxide	
INITIATION Prerequisites (tick box where appropriate)	
m O~ For patients with confirmed hypoglycaemia caused by hyperinsulinis	m

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:
Dulaglutide	

( or	J f	or c	ontinuation use
	and	С	Patient has type 2 diabetes
	and	С	Target HbA1c (of 53 mmol/mol or less) has not been achieved despite the regular use of all of the following funded blood glucose lowering agents for a period of least 6 months, where clinically appropriate: empagliflozin, metformin, and vildagliptin
	unu		O Patient is Māori or any Pacific ethnicity*
		or	O Patient has pre-existing cardiovascular disease or risk equivalent (see note a)*
		or	O Patient has an absolute 5-year cardiovascular disease risk of 15% or greater according to a validated cardiovascular risk assessment calculator*
		or	O Patient has a high lifetime cardiovascular risk due to being diagnosed with type 2 diabetes during childhood or as a young adult*
		or	O Patient has diabetic kidney disease (see note b)*

Note: \* Criteria intended to describe patients at high risk of cardiovascular or renal complications of diabetes.

- a) Pre-existing cardiovascular disease or risk equivalent defined as: prior cardiovascular disease event (i.e. angina, myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, transient ischaemic attack, ischaemic stroke, peripheral vascular disease), congestive heart failure or familial hypercholesterolaemia.
- Diabetic kidney disease defined as: persistent albuminuria (albumin:creatinine ratio greater than or equal to 3 mg/mmol, in at least two out of three b) samples over a 3-6 month period) and/or eGFR less than 60 mL/min/1.73m2 in the presence of diabetes, without alternative cause identified.
- Funded GLP-1a treatment is not to be given in combination with (empagliflozin / empagliflozin with metformin hydrochloride) unless receiving C) (empagliflozin or empagliflozin in combination with metformin hydrochloride) for the treatment of heart failure.

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:
Liraglutide	

or	0	For c	ontinuation use
•	and	0	Patient has type 2 diabetes
	and	0	Target HbA1c (of 53 mmol/mol or less) has not been achieved despite the regular use of all of the following funded blood glucose lowering agents for a period of least 6 months, where clinically appropriate: empagliflozin, metformin, and vildagliptin
			O Patient is Māori or any Pacific ethnicity*
		or	O Patient has pre-existing cardiovascular disease or risk equivalent (see note a)*
		or	O Patient has an absolute 5-year cardiovascular disease risk of 15% or greater according to a validated cardiovascular risk assessment calculator*
			O Patient has a high lifetime cardiovascular risk due to being diagnosed with type 2 diabetes during childhood or as a young adult*
		or	O Patient has diabetic kidney disease (see note b)*

- Note: \* Criteria intended to describe patients at high risk of cardiovascular or renal complications of diabetes.
- a) Pre-existing cardiovascular disease or risk equivalent defined as: prior cardiovascular disease event (i.e. angina, myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, transient ischaemic attack, ischaemic stroke, peripheral vascular disease), congestive heart failure or familial hypercholesterolaemia.
- Diabetic kidney disease defined as: persistent albuminuria (albumin:creatinine ratio greater than or equal to 3 mg/mmol, in at least two out of three b) samples over a 3-6 month period) and/or eGFR less than 60 mL/min/1.73m2 in the presence of diabetes, without alternative cause identified.
- Funded GLP-1a treatment is not to be given in combination with (empagliflozin / empagliflozin with metformin hydrochloride) unless receiving C) (empagliflozin or empagliflozin in combination with metformin hydrochloride) for the treatment of heart failure.

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:

### Empagliflozin; Empagliflozin with metformin hydrochloride

$\bigcap$			
and	Patient has heart failure		
	Patient is in NYHA functional class II or III or IV		
and			
	O Patient has a documented left ventricular ejection fraction (LVEF) of less the	han or equal to 40%	
no			
	$\odot$ An ECHO is not reasonably practicable, and in the opinion of the treating p	practitioner the patient would benefit from tre	atmen

#### **INITIATION – Type 2 Diabetes**

**Prerequisites** (tick boxes where appropriate)

	or	O f	or continuation use
	or	Ор	atient has previously had an initial approval for a GLP-1 agonist
		and (	O Patient has type 2 diabetes
		unu	O Patient is Māori or any Pacific ethnicity*
			or O Patient has pre-existing cardiovascular disease or risk equivalent (see note a)*
			or O Patient has an absolute 5-year cardiovascular disease risk of 15% or greater according to a validated cardiovascular risk assessment calculator*
			O Patient has a high lifetime cardiovascular risk due to being diagnosed with type 2 diabetes during childhood or as a young adult*
			O Patient has diabetic kidney disease (see note b)*
		and (	Target HbA1c (of 53 mmol/mol or less) has not been achieved despite the regular use of at least one blood-glucose lowering agent (e.g. metformin, vildagliptin, or insulin) for at least 3 months
No	te: * Cr	riteria ir	ntended to describe patients at high risk of cardiovascular or renal complications of diabetes.
a)	corona	ry inter	ardiovascular disease or risk equivalent defined as: prior cardiovascular disease event (i.e. angina, myocardial infarction, percutaneous vention, coronary artery bypass grafting, transient ischaemic attack, ischaemic stroke, peripheral vascular disease), congestive heart lial hypercholesterolaemia.
b)			ey disease defined as: persistent albuminuria (albumin:creatinine ratio greater than or equal to 3 mg/mmol, in at least two out of three a 3-6 month period) and/or eGFR less than 60 mL/min/1.73m2 in the presence of diabetes, without alternative cause.
c)			agliflozin / empagliflozin with metformin hydrochloride] treatment is not to be given in combination with a funded GLP-1 unless receiving / empagliflozin with metformin hydrochloride] for the treatment of heart failure.

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:	
Vard: NHI:		
Ursodeoxycholic acid		
INITIATION – Alagille syndrome or progressive familial intrahepatic chol Prerequisites (tick boxes where appropriate)	estasis	
O Patient has been diagnosed with Alagille syndrome or O Patient has progressive familial intrahepatic cholestasis		
INITIATION – Chronic severe drug induced cholestatic liver injury Prerequisites (tick boxes where appropriate)		
O Patient has chronic severe drug induced cholestatic liver injury and O Cholestatic liver injury not due to Total Parenteral Nutrition (TF and O Treatment with ursodeoxycholic acid may prevent hospital adm	PN) use in adults	
INITIATION – Primary biliary cholangitis         Prerequisites (tick boxes where appropriate)         O       Primary biliary cholangitis confirmed by antimitochondrial antibody titre (AMA) > 1:80, and raised cholestatic liver enzymes with or without raised serum IgM or, if AMA is negative by liver biopsy and O         Patient not requiring a liver transplant (bilirubin > 100 umol/l; decompensated cirrhosis		
INITIATION – Pregnancy Prerequisites (tick box where appropriate) O Patient diagnosed with cholestasis of pregnancy		
INITIATION – Haematological transplant Prerequisites (tick boxes where appropriate)		
O Patient at risk of veno-occlusive disease or has hepatic impair cell or bone marrow transplantation and O Treatment for up to 13 weeks	ment and is undergoing conditioning treatment prior to allogenic stem	
INITIATION – Total parenteral nutrition induced cholestasis Prerequisites (tick boxes where appropriate)		
Paediatric patient has developed abnormal liver function as inc and D Liver function has not improved with modifying the TPN compo		
INITIATION – prevention of sinusoidal obstruction syndrome Prerequisites (tick box where appropriate) O The individual has leukaemia/lymphoma and requires prophylaxis for syndrome	r medications/therapies with a high risk of sinusoidal obstruction	

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:	Name:
Ward:	NHI:
Methylnaltrexone bromide	
NITIATION – Opioid induced constipation	
Prerequisites (tick boxes where appropriate)	

()The patient is receiving palliative care and Oral and rectal treatments for opioid induced constipation are ineffective  $\bigcirc$ or  $\bigcirc$ Oral and rectal treatments for opioid induced constipation are unable to be tolerated

#### INITIATION – Opioid induced constipation outside of palliative care

Re-assessment required after 14 days

**Prerequisites** (tick boxes where appropriate)

 $\bigcirc$ and and

Individual has opioid induced constipation

Oral and rectal treatments for opioid induced constipation, including bowel-cleansing preparations, are ineffective or inappropriate

Mechanical bowel obstruction has been excluded

I confirm that the above details are correct:

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

 $\bigcirc$ 

and ( )

# 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:
sodium picosulfate	
INITIATION           Prerequisites (tick boxes where appropriate)	

The patient is a child with problematic constipation despite an adequate trial of other oral pharmacotherapies including macrogol where practicable

The patient would otherwise require a high-volume bowel cleansing preparation

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.

PRESC	RIBER	PATIENT:	
Name:		Name:	
Ward:		NHI:	

#### Betaine

()

Re-a		mer	ent required after 12 months s (tick boxes where appropriate)
and			scribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health Hospital.
	and	0	The patient has a confirmed diagnosis of homocystinuria
		or	O A cystathionine beta-synthase (CBS) deficiency
		or	A 5,10-methylene-tetrahydrofolate reductase (MTHFR) deficiency
	and		O A disorder of intracellular cobalamin metabolism
		0	An appropriate homocysteine level has not been achieved despite a sufficient trial of appropriate vitamin supplementation
	ITINU		ON

Re-assessment required after 12 months **Prerequisites** (tick box where appropriate)

O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

The treatment remains appropriate and the patient is benefiting from treatment

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:
Levocarnitine	

### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a neurologist, metabolic physician or metabolic disorders dietitian, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Sodium phenylbutyrate	
<b>INITIATION</b> Re-assessment required after 12 months <b>Prerequisites</b> (tick box where appropriate)	
	ordance with a protocol or guideline that has been endorsed by the Health

For the chronic management of a urea cycle disorder involving a deficiency of carbamylphosphate synthetase, ornithine transcarbamylase or argininosuccinate synthetase

#### CONTINUATION

()

and  $\bigcirc$ 

and

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

The treatment remains appropriate and the patient is benefiting from treatment

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:
Biotin	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a metabolic physician or metabolic disorders dietitian, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	
Pyridoxal-5-phosphate		

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a neurologist, metabolic physician or metabolic disorders dietitian, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:

### Galsulfase

Re-a		nt required after 12 months
Prero (	$\sim$	(tick boxes where appropriate) cribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health
and		lospital.
	and	The patient has been diagnosed with mucopolysaccharidosis VI
	01	O Diagnosis confirmed by demonstration of N-acetyl-galactosamine-4-sulfatase (arylsulfatase B) deficiency confirmed by either enzyme activity assay in leukocytes or skin fibroblasts
		O Detection of two disease causing mutations and patient has a sibling who is known to have mucopolysaccharidosis VI
Re-a		DN ht required after 12 months (tick boxes where appropriate)
( and		cribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health lospital.
	and	The treatment remains appropriate for the patient and the patient is benefiting from treatment
		Patient has not had severe infusion-related adverse reactions which were not preventable by appropriate pre-medication and/or adjustment of infusion rates
	and	Patient has not developed another life threatening or severe disease where the long term prognosis is unlikely to be influenced by Enzyme Replacement Therapy (ERT)

O Patient has not developed another medical condition that might reasonably be expected to compromise a response to ERT

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:

### Alglucosidase Alfa

#### INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and ( ) The patient is aged up to 24 months at the time of initial application and has been diagnosed with infantile Pompe disease and ( ) Diagnosis confirmed by documented deficiency of acid alpha-glucosidase by prenatal diagnosis using chorionic villus biopsies and/or cultured amniotic cells or Documented deficiency of acid alpha-glucosidase, and urinary tetrasaccharide testing indicating a diagnostic elevation of glucose tetrasaccharides or Documented deficiency of acid alpha-glucosidase, and documented molecular genetic testing indicating a disease-causing mutation in the acid alpha-glucosidase gene (GAA gene) or Documented urinary tetrasaccharide testing indicating a diagnostic elevation of glucose tetrasaccharides, and molecular genetic testing indicating a disease-causing mutation in the GAA gene and ) Patient has not required long-term invasive ventilation for respiratory failure prior to starting enzyme replacement therapy (ERT) and ()Patient does not have another life-threatening or severe disease where the prognosis is unlikely to be influenced by ERT or might be reasonably expected to compromise a response to ERT and Alglucosidase alfa to be administered at doses no greater than 20 mg/kg every 2 weeks

	ITINUA ssessn	TION nent required after 12 months
Prer	equisit	es (tick boxes where appropriate)
( and		escribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health Z Hospital.
		) The treatment remains appropriate for the patient and the patient is benefiting from treatment
	and and	<ul> <li>Alglucosidase alfa to be administered at doses no greater than 20 mg/kg every 2 weeks</li> <li>Patient has not had severe infusion-related adverse reactions which were not preventable by appropriate pre-medication and/or adjustment of infusion rates</li> </ul>
	and ( and	D Patient has not developed another life threatening or severe disease where the long term prognosis is unlikely to be influenced by ERT
	and	Patient has not developed another medical condition that might reasonably be expected to compromise a response to ERT
	( and	There is no evidence of life threatening progression of respiratory disease as evidenced by the needed for > 14 days of invasive ventilation
		D There is no evidence of new or progressive cardiomyopathy

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:

### Idursulfase

Re-a		men	t required after 24 weeks (tick boxes where appropriate)
Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and			
	( and	0	The patient has been diagnosed with Hunter Syndrome (mucopolysacchardosis II)
	unu	or	<ul> <li>Diagnosis confirmed by demonstration of iduronate 2-sulfatase deficiency in white blood cells by either enzyme assay in cultured skin fibroblasts</li> <li>Detection of a disease causing mutation in the iduronate 2-sulfatase gene</li> </ul>
	and (	0	Patient is going to proceed with a haematopoietic stem cell transplant (HSCT) within the next 3 months and treatment with idursulfase would be bridging treatment to transplant
an	( and (	0	Patient has not required long-term invasive ventilation for respiratory failure prior to starting Enzyme Replacement Therapy (ERT) Idursulfase to be administered for a total of 24 weeks (equivalent to 12 weeks pre- and 12 weeks post-HSCT) at doses no greater than 0.5 mg/kg every week

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:

### Laronidase

INITIAT			
Re-asse	essn	nen	t required after 24 weeks
Prerequ	uisit	tes	(tick boxes where appropriate)
O and			ribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.
a	( nd	C	The patient has been diagnosed with Hurler Syndrome (mucopolysacchardosis I-H)
		or	O Diagnosis confirmed by demonstration of alpha-L-iduronidase deficiency in white blood cells by either enzyme assay in cultured skin fibroblasts
			O Detection of two disease causing mutations in the alpha-L-iduronidase gene and patient has a sibling who is known to have Hurler syndrome
a	nd		
	) 	C	Patient is going to proceed with a haematopoietic stem cell transplant (HSCT) within the next 3 months and treatment with laronidase would be bridging treatment to transplant
	nd ( nd	C	Patient has not required long-term invasive ventilation for respiratory failure prior to starting Enzyme Replacement Therapy (ERT)
	(	C	Laronidase to be administered for a total of 24 weeks (equivalent to 12 weeks pre- and 12 post-HSCT) at doses no greater than 100 units/kg every week

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:

### Taliglucerase alfa

	ΙΑΤΙΟ			
Re-assessment required after 12 months				
Prer	equi	sites	(tick boxes where appropriate)	
and		Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
	anc	0	The patient has a diagnosis of symptomatic type 1 or type 3* Gaucher disease confirmed by the demonstration of specific deficiency of glucocerebrosidase in leukocytes or cultured skin fibroblasts, and genotypic analysis	
ar		0 I	Patient does not have another life-threatening or severe disease where the prognosis is unlikely to be influenced by enzyme replacement therapy (ERT) or the disease might be reasonably expected to compromise a response to ERT	
		or	O Patient has haematological complications of Gaucher disease	
		or	O Patient has skeletal complications of Gaucher disease	
		or	m O Patient has significant liver dysfunction or hepatomegaly attributable to Gaucher disease	
		or	O Patient has reduced vital capacity from clinically significant or progressive pulmonary disease due to Gaucher disease	
			O Patient is a child and has experienced growth failure with significant decrease in percentile linear growth over a 6-12 month period	
	anc	0	Taliglucerase alfa is to be administered at a dose no greater than 30 unit/kg every other week rounded to the nearest whole vial (200 units)	
Note	e: Ind	icatio	n marked with * is an unapproved indication	
CONTINUATION Re-assessment required after 3 years Prerequisites (tick boxes where appropriate)				
and			ribed by, or recommended by a metabolic physician or any relevant practitioner on the recommendation of a metabolic physician, or in dance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	
		0	Patient has demonstrated a symptomatic improvement and has maintained improvements in the main symptom or symptoms for which therapy was started	
	anc	0	Patient has demonstrated a clinically objective improvement or no deterioration in haemoglobin levels, platelet counts and liver and spleen size	
	anc	Ο	RRadiological (MRI) signs of bone activity performed at two years since initiation of treatment, and five yearly thereafter, demonstrate no deterioration shown by the MRI, compared with MRI taken immediately prior to commencement of therapy or adjusted dose	
	anc	Ο	Patient has not developed another medical condition that might reasonably be expected to compromise a response to ERT	
	ant	0	Patient is adherent with regular treatment and taliglucerase alfa is to be administered at a dose no greater than 30 unit/kg every other week rounded to the nearest whole vial (200 units)	

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:

### Sapropterin dihydrochloride

INITIATION				
Re-assessment required after 1 month Prerequisites (tick boxes where appropriate)				
	- -			
( and		escribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health Hospital.		
O Patient has phenylketonuria (PKU) and is pregnant or actively planning to become pregnant				
and Treatment with sapropterin is required to support management of PKU during pregnancy and Sapropterin to be administered at doses no greater than a total daily dose of 20 mg/kg and				
				<ul> <li>Sapropterin to be used alone or in combination with PKU dietary management</li> <li>Total treatment duration with sapropterin will not exceed 22 months for each pregnancy (includes time for planning and becoming pregnant) and treatment will be stopped after delivery</li> </ul>
Re-a	CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
	and	<ul> <li>Following the initial one-month approval, the patient has demonstrated an adequate response to a 2 to 4 week trial of sapropterin with a clinically appropriate reduction in phenylalanine levels to support management of PKU during pregnancy</li> <li>On subsequent renewal applications, the patient has previously demonstrated response to treatment with sapropterin and maintained adequate phenylalanine levels to support management of PKU during pregnancy</li> <li>Patient continues to be pregnant and treatment with sapropterin will not continue after delivery</li> <li>Patient is actively planning a pregnancy and this is the first renewal for treatment with sapropterin</li> </ul>		
		O Treatment with sapropterin is required for a second or subsequent pregnancy to support management of their PKU during pregnancy		
and O Sapropterin to be administered at doses no greater than a total daily dose of 20 mg/kg and O Sapropterin to be used alone or in combination with PKU dietary management and				
O Total treatment duration with sapropterin will not exceed 22 months for each pregnancy (includes time for planning and become pregnant) and treatment will be stopped after delivery				

and

#### 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:		
Carglumic Acid			
INITIATION           Prerequisites (tick box where appropriate)			

()Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

O For the acute in-patient treatment of organic acidaemias as an alternative to haemofiltration

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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:		
Coenzyme Q10			
INITIATION Re-assessment required after 6 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O The patient has a suspected inborn error of metabolism that may respond to coenzyme Q10 supplementation			
CONTINUATION         Re-assessment required after 24 months         Prerequisites (tick boxes where appropriate)         O       Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.         and       O         The patient has a confirmed diagnosis of an inborn error of metabolism that responds to coenzyme Q10 supplementation         O       The treatment remains appropriate and the patient is benefiting from treatment			

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:		
Riboflavin			
INITIATION         Re-assessment required after 6 months         Prerequisites (tick box where appropriate)         O       Prescribed by, or recommended by a metabolic physician or neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.         and       O         The patient has a suspected inborn error of metabolism that may respond to riboflavin supplementation			
CONTINUATION         Re-assessment required after 24 months         Prerequisites (tick boxes where appropriate)         O       Prescribed by, or recommended by a metabolic physician or neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.         and       O         The patient has a confirmed diagnosis of an inborn error of metabolism that responds to riboflavin supplementation         O       The treatment remains appropriate and the patient is benefiting from treatment			

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:	
Taurine		
INITIATION         Re-assessment required after 6 months         Prerequisites (tick box where appropriate)         O       Prescribed by, or recommended by a metabolic physician, or in acconnected by a metabolic physician.         and       O         The patient has a suspected specific mitochondrial disorder that may	rdance with a protocol or guideline that has been endorsed by the Health y respond to taurine supplementation	
CONTINUATION Re-assessment required after 24 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O The patient has a confirmed diagnosis of a specific mitochondrial disorder which responds to taurine supplementation O The treatment remains appropriate and the patient is benefiting from treatment		

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:
Trientine		
INITIATION         Prerequisites (tick boxes where appropriate)         O       Patient has confirmed Wilson disease         and       O         Treatment with D-penicillamine has been trialled and discontinued because the person has experienced intolerable side effects or has not received sufficient benefit         and       Treatment with zinc has been trialled and discontinued because the person has experienced intolerable side effects or has not received sufficient benefit, or zinc is considered clinically inappropriate as the person has symptomatic liver disease and requires copper chelation		
	received sufficient benefit, or zinc is considered clinically inapp	

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.

PRES	SCRIBER	PATIENT:	
Name	5:	Name:	
Ward	:	NHI:	
Сор	per chloride		
Re-a	ATION – Moderate to severe burns ssessment required after 3 months		
Prerequisites (tick boxes where appropriate)			
	O Patient has been hospitalised with moderate to severe burns		
	O Treatment is recommended by a National Burns Unit specialis	t	

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:		
Ferric carboxymaltose			
INITIATION Prerequisites (tick box where appropriate)			
O Treatment with oral iron has proven ineffective or is clinically inappro	ppriate		

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.

PRES	SCRIBER	PATIENT:
Name	e:	Name:
Ward	k	NHI:
Sele	nium	
	IATION – Moderate to severe burns assessment required after 3 months	
Prerequisites (tick boxes where appropriate)		
	O Patient has been hospitalised with moderate to severe burns	
	O Treatment is recommended by a National Burns Unit specialis	t

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:		
Sodium hyaluronate			

#### INITIATION

Prerequisites (tick box where appropriate)

()Prescribed by, or recommended by an otolaryngologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

I confirm that the	above details	are correct:
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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.

PRES	CRI	BER		PATIENT:
Name	:			Name:
Ward:				NHI:
Multi	vita	amir	is - Cap	
INITI. Prere			(tick boxes where appropriate)	
		0	Patient has cystic fibrosis with pancreatic insufficiency	
	or	Ο	Patient is an infant or child with liver disease or short gut synd	rome
	or	0	Patient has severe malabsorption syndrome	

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:
Multivitamins – Powder	
INITIATION           Prerequisites (tick box where appropriate)	
O Patient has inborn errors of metabolism	

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.

PRESC	RIB	ER			PATIENT:
Name:					Name:
Ward: .					NHI:
Multiv	itar	nin	and	mineral supplement	
Prereq	sessr	ment tes (	tick b	ired after 3 months boxes where appropriate) nt was admitted to hospital with burns	
a		or or	0 0 0	Burn size is greater than 15% of total body surface area Burn size is greater than 10% of BSA for mid-dermal or o Nutritional status prior to admission or dietary intake is p	deep dermal burns

or

# 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:
Multivitamin renal	
INITIATION           Prerequisites (tick boxes where appropriate)	

 $\bigcirc$ The patient has chronic kidney disease and is receiving either peritoneal dialysis or haemodialysis

The patient has chronic kidney disease grade 5, defined as patient with an estimated glomerular filtration rate of < 15 ml/min/1.73m<sup>2</sup> body surface area (BSA)

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.

PRES	SCRIE	BER	PATIENT:	
Name	e:		Name:	
Ward	:		NHI:	
Alph	a to	сор	heryl acetate	
			Cystic fibrosis (tick boxes where appropriate)	
	and	0	Cystic fibrosis patient	
		or	<ul> <li>Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck)</li> <li>The other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate the patient</li> </ul>	ate for
	equis	ites	Osteoradionecrosis (tick box where appropriate) e treatment of osteoradionecrosis	
			Other indications (tick boxes where appropriate)	
	and	0	Infant or child with liver disease or short gut syndrome	
	and	0	Requires vitamin supplementation	
			O Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplements (Vitabdeck)	
		or	O The other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically inappropriation	ate for

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:		

### Alpha tocopheryl

		Cystic fibrosis (tick boxes where appropriate)
( and	С	Cystic fibrosis patient
	or	O Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck)
		O The other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate for the patient
equis	ites	Disteoradionecrosis (tick box where appropriate) e treatment of osteoradionecrosis
 		Other indications (tick boxes where appropriate)
( and	С	Infant or child with liver disease or short gut syndrome
and (	С	Requires vitamin supplementation
	or	O Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplements (Vitabdeck)
		O The other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate for patient

**Blood and Blood Forming Organs** 

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:		

### **Epoetin beta**

and	) Patie	ent in chronic renal failure
and	) Haer	moglobin is less than or equal to 100g/L
anu		
	an	O Patient does not have diabetes mellitus
		O Glomerular filtration rate is less than or equal to 30ml/min
	or	
		O Patient has diabetes mellitus
	an	O Glomerular filtration rate is less than or equal to 45ml/min

#### INITIATION – myelodysplasia\*

Re-assessment	t required	after 1	12 months	;

Prerequisites (tick boxes where appropriate)

and	Patient has a confirmed diagnosis of myelodysplasia (MDS)
and	Has had symptomatic anaemia with haemoglobin < 100g/L and is red cell transfusion-dependent
	Patient has very low, low or intermediate risk MDS based on the WHO classification-based prognostic scoring system for myelodysplastic syndrome (WPSS)
and O	Other causes of anaemia such as B12 and folate deficiency have been excluded
and O and	Patient has a serum epoetin level of < 500 IU/L
0	The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week

### CONTINUATION – myelodysplasia\*

Re-assessment required after 2 months
Prerequisites (tick boxes where appropriate)
O
The patient's transfusion requirement continues to be reduced with epoetin treatment
and
O
Transformation to acute myeloid leukaemia has not occurred
and
O
The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week

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:
Epoetin beta - continued	
INITIATION – all other indications Prerequisites (tick boxes where appropriate)	
Haematologist	
O For use in patients where blood transfusion is not a viable trea	atment alternative
and *Note: Indications marked with * are unapproved indications	

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:		

#### **Epoetin alfa**

C	Patient in	chronic renal failure	
and C and	Haemoglo	obin is less than or equal to 100g/L	
	and	<ul> <li>Patient does not have diabetes mellitus</li> <li>Glomerular filtration rate is less than or equal to 30ml/min</li> </ul>	
c	or and	<ul> <li>Patient has diabetes mellitus</li> <li>Glomerular filtration rate is less than or equal to 45ml/min</li> </ul>	

### INITIATION – myelodysplasia\*

and

and

and

and

and

and

Re-assessment required after 2 months

Prerequisites (tick boxes where appropriate)

	$\sim$		
(	$\cup$	Patient has a confirmed diagnosis of myelodysplasia (	MDS

Has had symptomatic anaemia with haemoglobin < 100g/L and is red cell transfusion-dependent

O Patient has very low, low or intermediate risk MDS based on the WHO classification-based prognostic scoring system for myelodysplastic syndrome (WPSS)

 $\odot~$  Other causes of anaemia such as B12 and folate deficiency have been excluded

 ${\sf O}\,$  Patient has a serum epoetin level of < 500 IU/L

The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week

### CONTINUATION – myelodysplasia\*

Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

O The patient's transfusion requirement continues to be reduced with epoetin treatment and

O Transformation to acute myeloid leukaemia has not occurred

The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week

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:			
Epoetin alfa - continued				
INITIATION – all other indications				
Prerequisites (tick box where appropriate)				
O Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
O For use in patients where blood transfusion is not a viable treatment	alternative			
Note: Indications marked with * are unapproved indications				

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	e:			Name:
Ward	:			NHI:
Apro	otin	in		
INITI Prer (		Preso	(tick boxes where appropriate) cribed by, or recommended by a cardiac anaesthetist, or in according on the second second second second second	ordance with a protocol or guideline that has been endorsed by the Health
and		0	Paediatric patient undergoing cardiopulmonary bypass procec	lure
	or	0	Adult patient undergoing cardiac surgical procedure where the effects of the drug	e significant risk of massive bleeding outweighs the potential adverse

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:	
Eltro	Eltrombopag					
Re-a	Hospital.			uired after 6 weeks boxes where appropriate)	ce with a protocol or guideline that has been endorsed by the Health NZ	
	anc	Ο		ent has had a splenectomy immunosuppressive therapies have been trialled and fail	ed after therapy of 3 months each (or 1 month for rituximab)	
		or	0 0 0		s per microlitre and has evidence of significant mucocutaneous bleeding 000 platelets per microlitre and has evidence of active bleeding 000 platelets per microlitre	
Re-a	INITIATION – idiopathic thrombocytopenic purpura - preparation for splenectomy Re-assessment required after 6 weeks Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O The patient requires eltrombopag treatment as preparation for splenectomy					
Re-a Prero ( and	CONTINUATION – idiopathic thrombocytopenic purpura - post-splenectomy Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O The patient has obtained a response (see Note) from treatment during the initial approval or subsequent renewal periods and further treatment is required Note: Response to treatment is defined as a platelet count of > 30,000 platelets per microlitre					
INITIATION - idiopathic thrombocytopenic purpura contraindicated to splenectomy         Re-assessment required after 3 months         Prerequisites (tick boxes where appropriate)         O       Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.         and						
	anc	Ο		Patient has immune thrombocytopenic purpura* with a	n to splenectomy for clinical reasons ed after therapy of 3 months each (or 1 month for rituximab) platelet count of less than or equal to 20,000 platelets per microliter platelet count of 20,000 to 30,000 platelets per microlitre and significant	

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:	Name:					
Ward:	NHI:					
Eltrombopag - continued						
CONTINUATION – idiopathic thrombocytopenic purpura contraindicated Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	e with a protocol or guideline that has been endorsed by the Health NZ ins e initial approval period elets per microlitre on treatment					
Hospital. and Two immunosuppressive therapies have been trialled and faile and O Patient has severe aplastic anaemia with a platelet count or						
and Hospital.	ee with a protocol or guideline that has been endorsed by the Health NZ t 20,000 platelets per microlitre above baseline during the initial approval during the initial approval period					
Platelet transfusion independence for a minimum of 8 weeks c	luring the initial approval period					

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:	Name:
Ward:	NHI:
Aluminium chloride	
INITIATION Prerequisites (tick box where appropriate)	
O For use as a haemostatis agent	

and ( )

#### **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:
Emicizumab	

### INITIATION - Severe Haemophilia A with or without FVIII inhibitors

Prerequisites (tick boxes where appropriate)

()Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and

Patient has severe congenital haemophilia A with a severe bleeding phenotype (endogenous factor VIII activity less than or equal to 2%)

Emicizumab is to be administered at a dose of no greater than 3 mg/kg weekly for 4 weeks followed by the equivalent of 1.5 mg/kg weekly

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:			
Idarucizumab				

### INITIATION

Prerequisites (tick box where appropriate)

()For the reversal of the anticoagulant effects of dabigatran when required in situations of life-threatening or uncontrolled bleeding, or for emergency surgery or urgent procedures

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:	
Moroctocog alfa [Recombinant factor VIII]		

### INITIATION

Prerequisites (tick box where appropriate)

For patients with haemophilia. Rare Clinical Circumstances Brand of short half-life recombinant factor VIII. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group, subject to criteria ()

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:	
Octocog alfa [Recombinant factor VIII] (Advate)		

### INITIATION

Prerequisites (tick box where appropriate)

()For patients with haemophilia. Preferred Brand of short half-life recombinant factor VIII. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group

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:
Octocog alfa [Recombinant factor VIII] (Kogenate FS)	

#### INITIATION

Prerequisites (tick box where appropriate)

For patients with haemophilia. Rare Clinical Circumstances Brand of short half-life recombinant factor VIII. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group, subject to criteria ()

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:	
Nonacog gamma		

#### INITIATION

Prerequisites (tick box where appropriate)

()For patients with haemophilia. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group

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:	
Rurioctocog alfa pegol [Recombinant factor VIII]		

### INITIATION

Prerequisites (tick box where appropriate)

For patients with haemophilia A receiving prophylaxis treatment. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group ()

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:	
Eftrenonacog alfa		

### INITIATION

Prerequisites (tick box where appropriate)

For patients with haemophilia B receiving prophylaxis treatment. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group ()

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:	
Factor eight inhibitor bypassing fraction		

#### INITIATION

Prerequisites (tick box where appropriate)

For patients with haemophilia. Preferred Brand of bypassing agent for > 14 days predicted use. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group ()

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:	
Eptacog alfa		

#### INITIATION

Prerequisites (tick box where appropriate)

()For patients with haemophilia. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group. Rare Clinical Circumstances Brand of bypassing agent for > 14 days predicted use. Access to funded treatment for > 14 days predicted use is by named patient application to the Haemophilia Treaters Group, subject to access criteria

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.

PRES	CR	IBER	PATIENT:
Name	:		Name:
Ward:			NHI:
Bival	iru	ıdin	
INITI Prere		ON isites (tick boxes where appropriate)	
	O For use in heparin-induced thrombocytopaenia, heparin resistance or heparin intolerance or		
O For use in patients undergoing endovascular procedures			
$\subseteq$			

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:
Danaparoid	
INITIATION Prerequisites (tick box where appropriate)	

O For use in heparin-induced thrombocytopaenia, heparin resistance or heparin intolerance

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.

PRESCR	IBER	PATIENT:
Name:		Name:
Ward:		NHI:
Defibrotide		
INITIATION           Prerequisites (tick box where appropriate)		
0	Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	
and	Patient has moderate or severe sinusoidal obstruction syndrome as a result of chemotherapy or regimen-related toxicities	

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:	
Fondaparinux sodium		
INITIATION Prerequisites (tick box where appropriate)		

O For use in heparin-induced thrombocytopaenia, heparin resistance or heparin intolerance

and ( )

# 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:	
Lysine acetylsalicylate		
Prerequisites (tick boxes where appropriate)		

 $\bigcirc$ For use when an immediate antiplatelet effect is required prior to an urgent interventional neuro-radiology or interventional cardiology procedure

Administration of oral aspirin would delay the procedure

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	ł	PATIENT:
Name:		Name:
Ward:		NHI:
Eptifibatide		
INITIATION         Prerequisites (tick boxes where appropriate)         O       For use in patients with acute coronary syndromes undergoing percutaneous coronary intervention         or       O       For use in patients with definite or strongly suspected intra-coronary thrombus on coronary angiography         or       O       For use in patients with definite or strongly suspected intra-coronary thrombus on coronary angiography         or       O       For use in patients undergoing intra-cranial intervention		

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.

PRESCRI	BER	PATIENT:	
Name:		Name:	
Ward:		NHI:	
Ticagre	lor		
0	i <b>sites</b> ( Restri an ST	ick box where appropriate) eted to treatment of acute coronary syndromes specifically for patients who have recently (within the last 60 days) been diagnosed wit elevation or a non-ST-elevation acute coronary syndrome, and in whom fibrinolytic therapy has not been given in the last 24 hours an olanned	
Re-asses	ssment	rombosis prevention neurological stenting required after 12 months ick boxes where appropriate)	
	or	<ul> <li>Patient has had a neurological stenting procedure* in the last 60 days</li> <li>Patient is about to have a neurological stenting procedure performed*</li> </ul>	
and	d or	O Patient has demonstrated clopidogrel resistance using the P2Y12 (VerifyNow) assay or another appropriate platelet function assay and requires antiplatelet treatment with ticagrelor	
		O Clopidogrel resistance has been demonstrated by the occurrence of a new cerebral ischemic event O Clopidogrel resistance has been demonstrated by the occurrence of transient ischemic attack symptoms referable to the stent.	
Re-asses	isites	A – thrombosis prevention neurological stenting required after 12 months ick boxes where appropriate) Patient is continuing to benefit from treatment	
and	-	Treatment continues to be clinically appropriate	
Re-asses	ssment	ercutaneous coronary intervention with stent deployment required after 12 months ick boxes where appropriate)	
and	d	Patient has undergone percutaneous coronary intervention	
and		Patient has had a stent deployed in the previous 4 weeks Patient is clopidogrel-allergic**	
		ent thrombosis ick box where appropriate)	
0	Patier	has experienced cardiac stent thrombosis whilst on clopidogrel	
Re-asses	ssment	yocardial infarction required after 1 week ick box where appropriate)	
0	For sh	ort term use while in hospital following ST-elevated myocardial infarction	
I confirm th	hat 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:	Name:	
Ward:	NHI:	

### Ticagrelor - continued

Note: Indications marked with \* are unapproved indications. Note: Note: \*\* Clopidogrel allergy is defined as a history of anaphylaxis, urticaria, generalised rash or asthma (in non-asthmatic patients) developing soon after clopidogrel is started and is considered unlikely to be caused by any other treatment

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.

PRESCRIBI	ER	PATIENT:
Name:		Name:
Ward:		NHI:
Plerixafor	r	
Re-assessr Prerequisit	I – Autol ment req tes (tick rescriber ospital. D Pati Pati	logous stem cell transplant   uired after 3 days   boxes where appropriate)   d by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ent is to undergo stem cell transplantation ent has not had a previous unsuccessful mobilisation attempt with plerixafor O Patient is undergoing G-CSF mobilisation O Has a suboptimal peripheral blood CD34 count of less than or equal to 10 × 10 <sup>6</sup> /L on day 5 after 4 days of G-CSF or O Efforts to collect > 1 × 10 <sup>6</sup> CD34 cells/kg have failed after one apheresis procedure O Patient is undergoing chemotherapy and G-CSF mobilisation Ind O Has rising white blood cell counts of > 5 × 10 <sup>9</sup> /L
		O       Has a suboptimal peripheral blood CD34 count of less than or equal to 10 × 10 <sup>6</sup> /L         or       O       Efforts to collect > 1 × 10 <sup>6</sup> CD34 cells/kg have failed after one apheresis procedure         or       O       The peripheral blood CD34 cell counts are decreasing before the target has been received
	or O	A previous mobilisation attempt with G-CSF or G-CSF plus chemotherapy has failed

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:	
Pegfilgrastim		

#### INITIATION

Prerequisites (tick box where appropriate)

O For prevention of neutropenia in patients undergoing high risk chemotherapy for cancer (febrile neutropenia risk greater than or equal to 5%\*) Note: \*Febrile neutropenia risk greater than or equal to 5% after taking into account other risk factors as defined by the European Organisation for Research and Treatment of Cancer (EORTC) guidelines

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:
Filgrastim	

### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a haematologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:			
Sodium chloride – Inj				
INITIATION Prerequisites (tick box where appropriate)				
O For use in flushing of in-situ vascular access devices only				

### Cardiovascular System

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.

PRES	SCRI	BER		PATIENT:
Name	e:			Name:
Ward:	:			NHI:
Capt	opr	il - C	Dral liq 5 mg per ml	
INITI Prero			(tick boxes where appropriate)	
		Ο	For use in children under 12 years of age	
O For use in tube-fed patients			For use in tube-fed patients	
	or	0	For management of rebound transient hypertension following	cardiac surgery

and

and  $\bigcirc$ 

# 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.

PRES	SCRIB	ER		PATIENT:
Name	ə:			Name:
Ward	:			NHI:
Sacı	ubitri	il wi	ith valsartan	
	IATIOI equis		(tick boxes where appropriate)	
	and	О	Patient has heart failure	
		or	O Patient is in NYHA/WHO functional class II	
	O Patient is in NYHA/WHO functional class III		O Patient is in NYHA/WHO functional class III	
		or	O Patient is in NYHA/WHO functional class IV	

	Ο	Patient has a documented left ventricular ejection fraction (LV	VEF) of les	ss than or equa	al to 35%	
or	_					

O An ECHO is not reasonably practical, and in the opinion of the treating practitioner the patient would benefit from treatment

Patient is receiving concomitant optimal standard chronic heart failure treatments

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:
Adenosine - Inj 3 mg per ml, 10 ml vial	
INITIATION           Prerequisites (tick box where appropriate)	
O For use in cardiac catheterisation, electrophysiology and MRI	

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:		
Ajmaline			

Prerequisites (tick box where appropriate)

()Prescribed by, or recommended by a cardiologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

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.

PRES	CRIB	ER		PATIENT:
Name	:			Name:
Ward:				NHI:
lvabı	adir	ne		
INITI Prere			(tick boxes where appropriate)	
	( and	С	Patient is indicated for computed tomography coronary angiog	raphy
	<ul> <li>O Patient has a heart rate of greater than 70 beats per minute while taking a maximally tolerated dose of beta blocker</li> <li>O Patient is unable to tolerate beta blockers</li> </ul>			ute while taking a maximally tolerated dose of beta blocker

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:
Midodrine	
INITIATION Prerequisites (tick box where appropriate)	
O Patient has disabling orthostatic hypotension not due to drugs	

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:
Nicardipine hydrochloride	

Prer			where appropriate)
( and	С		r recommended by an anaesthetist, intensivist, cardiologist or paediatric cardiologist, or in accordance with a protocol or is been endorsed by the Health NZ Hospital.
		O Patient has	s hypertension requiring urgent treatment with an intravenous agent
	or	O Patient has	s excessive ventricular afterload
	or	O Patient is a	awaiting or undergoing cardiac surgery using cardiopulmonary bypass

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.

PRES	CRIB	ER			PATIENT:
Name	:				Name:
Ward:					NHI:
Eple	reno	ne			
	ATION equisi	-	(tick k	poxes where appropriate)	
Patient has heart failure with ejection fraction less than 40%     O Patient is intolerant to optimal dosing of spironolactone					
			0		
		or	0	Patient has experienced a clinically significant adverse e	ffect while on optimal dosing of spironolactone

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:
Tabaantaa	

### Tolvaptan

# INITIATION - autosomal dominant polycystic kidney disease Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a renal physician or any relevant practitioner on the recommendation of a renal physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Patient has a confirmed diagnosis of autosomal dominant polycystic kidney disease and O Patient has an estimated glomerular filtration rate (eGFR) of greater than or equal to 25 ml/min/1.73 m<sup>2</sup> at treatment initiation or O Patient's disease is rapidly progressing, with a decline in eGFR of greater than or equal to 2.5 mL/min/1.73 m<sup>2</sup> per year over a five-year period

CONTINUATION – autosomal dominant polycystic kidney disease Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a renal physician or any relevant practitioner on the recommendation of a renal physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Patient has not developed end-stage renal disease, defined as an eGFR of less than 15 mL/min/1.73 m<sup>2</sup> Patient has not undergone a kidney transplant

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:	

### Rosuvastatin

INITIATION – cardiovascular disease risk Prerequisites (tick boxes where appropriate)		
	O Patient is considered to be at risk of cardiovascular disease and O Patient is Māori or any Pacific ethnicity	
	or	Patient has a calculated risk of cardiovascular disease of at least 15% over 5 years LDL cholesterol has not reduced to less than 1.8 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or simvastatin
		I – familial hypercholesterolemia tes (tick boxes where appropriate)
Patient has familial hypercholesterolemia (defined as a Dutch Lipid Criteria score greater than or equal to 6) and D LDL cholesterol has not reduced to less than 1.8 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or simvastatin		
		I – established cardiovascular disease tes (tick boxes where appropriate)
		or       O       Patient has proven coronary artery disease (CAD)         or       O       Patient has proven peripheral artery disease (PAD)         or       O       Patient has experienced an ischaemic stroke
and LDL cholesterol has not reduced to less than 1.4 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or simvastatin		
		I – recurrent major cardiovascular events tes (tick boxes where appropriate)
	and	Patient has experienced a recurrent major cardiovascular event (defined as myocardial infarction, ischaemic stroke, coronary revascularisation, hospitalisation for unstable angina) in the last 2 years

LDL cholesterol has not reduced to less than 1.0 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or

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:
Levosimendan	
INITIATION – Heart transplant         Prerequisites (tick boxes where appropriate)         O       For use as a bridge to heart transplant, in patients who have be or         or       O         For the treatment of heart failure following heart transplant	een accepted for transplant
INITIATION – Heart failure           Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a cardiologist or intensivist, or in Health NZ Hospital.	accordance with a protocol or guideline that has been endorsed by the

O For the treatment of severe acute decompensated heart failure that is non-responsive to dobutamine

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.

PATIENT:
Name:
NHI:

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:	
Hydı	Hydralazine hydrochloride - Tab 25 mg			
INITI Prer			(tick boxes where appropriate)	
	O For the treatment of refractory hypertension			
or Sor the treatment of heart failure, in combination with a nitrate, in patients who are intolerant or have not responded to ACE inhibitor and/or angiotensin receptor blockers				

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.

PRESC	RIBER	PATIENT:		
Name:		Name:		
Ward: .		NHI:		
bosen	tan			
INITIATION – PAH monotherapy           Re-assessment required after 6 months				
Prereq	uisites (tick boxes where appropriate)			
and	Prescribed by, or recommended by a respiratory specialist, cardiologial a respiratory specialist, cardiologist or rheumatologist, or in accordated Hospital.	gist, rheumatologist or any relevant practitioner on the recommendation of nce with a protocol or guideline that has been endorsed by the Health NZ		
	-			

י ב	Hospit	aı.	
and		Patie	nt has pulmonary arterial hypertension (PAH)*
and	Ο	PAH	is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications
and	O	PAH	is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
			O PAH has been confirmed by right heart catheterisation
		an	O A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)
		an	O A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg
		an	O Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm <sup>-5</sup> )
			O PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †
			O Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**
			O Patient has PAH other than idiopathic / heritable or drug-associated type
	or or	0	Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease
		0	Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures
and		~	
	and	$\bigcirc$	Bosentan is to be used as PAH monotherapy
		or	O Patient has experienced intolerable side effects on sildenafil
		or	O Patient has an absolute contraindication to sildenafil
			O Patient is a child with idiopathic PAH or PAH secondary to congenital heart disease
1			

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

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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.

PRESCRIBEF	2	PATIENT:
Name:		Name:
Ward:		NHI:
bosentan -	continu	ed
	ent requi	ual therapy red after 6 months oxes where appropriate)
O Pres a re	scribed	by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of y specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
Ο	Patie	nt has pulmonary arterial hypertension (PAH)*
and and and	PAH i	s in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications
and	PAH	s in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
0	0	<ul> <li>A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)</li> <li>A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg</li> <li>Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm<sup>-5</sup>)</li> <li>PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †</li> <li>Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**</li> <li>Patient has PAH other than idiopathic / heritable or drug-associated type</li> </ul>
and		
a	or	Bosentan is to be used as part of PAH dual therapy         O       Patient has tried a PAH monotherapy (sildenafil) for at least three months and has experienced an inadequate therapeutic response to treatment according to a validated risk stratification tool**         O       Patient is presenting in NYHA/WHO functional class III or IV, and in the opinion of the treating clinician would likely benefit from initial dual therapy

Signed:	Date:
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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.

Name:	
Ward: NHI:	
bosentan - continued	
INITIATION – PAH triple therapy Re-assessment required after 6 months         Prerequisites (tick boxes where appropriate)         Prescribed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist, or in accordance with a protocol or guideline that has been endorsed by the Health N: Hospital.         and       Patient has pulmonary arterial hypertension (PAH)*         and       PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications and         PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV and         and       PAH has been confirmed by right heart catheterisation         and       PAH has been confirmed by right heart catheterisation         and       A mean pulmonary artery pressure (PCWP) less than or equal to 15 mmHg         and       Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm <sup>-5</sup> )         and       PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †         or       Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**	(dyn s cm <sup>-5</sup> ) ost or nitric oxide, as es) †
<ul> <li>or</li> <li>Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disease</li> <li>Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures</li> <li>and</li> <li>Bosentan is to be used as part of PAH triple therapy</li> <li>Patient is on the lung transplant list</li> <li>Or</li> <li>Patient is presenting in NYHA/WHO functional class IV</li> <li>Or</li> <li>Patient has tried PAH dual therapy for at least three months and has not experienced an acceptable response to treatment according to a validated risk stratification tool**</li> <li>Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario</li> </ul>	ajor complication of the

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.

PRESCR	IBER	PATIENT:
Name:		Name:
Ward:		NHI:
bosenta	an - continued	
	<b>UATION</b> ssment required after 2 years <b>isites</b> (tick box where appropriate)	
and		gist, rheumatologist or any relevant practitioner on the recommendation of nce with a protocol or guideline that has been endorsed by the Health NZ
O	Patient is continuing to derive benefit from bosentan treatment accord	rding to a validated PAH risk stratification tool**

Note: † The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the	16
diagnosis and treatment of pulmonary hypertension PAH	
** the requirement to use a validated risk stratification tool to determine insufficient response applies to adult	s
Determining insufficient response in children does not require use of a validated PAH risk stratification tool, whe	re
currently no such validated tools exist for PAH risk stratification in children.	

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:

### Ambrisentan

Re-a	NITIATION – PAH monotherapy Re-assessment required after 6 months					
Prer	equis	ites (t	ick bo	exes where appropriate)		
( and	а		ratory	by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of r specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ		
	( and	D f	Patier	t has pulmonary arterial hypertension (PAH)		
	( and	F C	PAH is	s in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications		
	( and	J F	PAH i	s in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV		
			and	O PAH has been confirmed by right heart catheterisation		
			and	O A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)		
			and	O A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg		
			and	O Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm <sup>-5</sup> )		
				O PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †		
				O Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**		
				O Patient has PAH other than idiopathic / heritable or drug-associated type		
		or or		Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease		
				Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures		
	and		О	Ambrisentan is to be used as PAH monotherapy		
		and		O Patient has experienced intolerable side effects with both sildenafil and bosentan		
			or	O Patient has an absolute contraindication to sildenafil and an absolute or relative contraindication to bosentan (e.g. due to current use of a combined oral contraceptive or liver disease)		
			or	O Patient is a child with idiopathic PAH or PAH secondary to congenital heart disease		
			_			

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.

PRES	CRIBI	ER		PATIENT:
Name	ame: Name:			
Nard:				NHI:
۱mb	risen	ntan	- con	inued
<b>INITI</b> Re-as	ATION ssessr equisit O Pi a	<b>I – PA</b> ment i <b>tes</b> (ti respii lospita	AH du requir ick bo bed b ratory al. Patien PAH is	In the appropriate of months ease where appropriate) t, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ has pulmonary arterial hypertension (PAH) in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV PAH has been confirmed by right heart catheterisation A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair) A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm <sup>-5</sup> ) PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †
	and	or or ( and	O I	<ul> <li>Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**</li> <li>Patient has PAH other than idiopathic / heritable or drug-associated type</li> <li>atient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung isorders including chronic neonatal lung disease</li> <li>atient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the ontan circulation requiring the minimising of pulmonary/venous filling pressures</li> <li>Patient has tried bosentan (either as PAH dual therapy</li> <li>Patient has not experienced an acceptable response to treatment according to a validated risk stratification tool**</li> <li>Patient has an absolute or relative contraindication to bosentan (e.g. due to current use of a combined oral contraceptive or liver disease)</li> <li>Patient is presenting in NYHA/WHO functional class III or IV, and would benefit from initial dual therapy in the opinion of the treating clinician and has an absolute or relative contraindication to bosentan (e.g. due to current liver disease or use of a combined oral contraceptive)</li> </ul>

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.

RESCRIBER	PATIENT:		
ame:	me: Name:		
/ard:	NHI:		
mbrisenta	n - continued		
Re-assessmer Prerequisites Prese ares Hosp and and and	PAH triple therapy t required after 6 months (tick boxes where appropriate) pribed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of piratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital. Patient has pulmonary arterial hypertension (PAH) PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV		
and or or	<ul> <li>PAH has been confirmed by right heart catheterisation</li> <li>A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)</li> <li>A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg</li> <li>Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm<sup>-5</sup>)</li> <li>PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †</li> <li>Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**</li> <li>Patient has PAH other than idiopathic / heritable or drug-associated type</li> <li>Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disease</li> <li>Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures</li> </ul>		
and	<ul> <li>Ambrisentan is to be used as PAH triple therapy</li> <li>Patient is on the lung transplant list</li> <li>Patient is presenting in NYHA/WHO functional class IV</li> <li>and</li> <li>Patient has an absolute or relative contraindication to bosentan (e.g. due to current use of a combined oral contraceptive or liver disease)</li> <li>Patient has tried PAH dual therapy for at least three months and remains in an unacceptable risk category according to a validated risk stratification tool**</li> <li>Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario</li> </ul>		

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:	Name:
Ward:	NHI:
Ambrisentan - continued	
	gist, rheumatologist or any relevant practitioner on the recommendation of nce with a protocol or guideline that has been endorsed by the Health NZ nt according to a validated PAH risk stratification tool**
Note: † The European Respiratory Journal Guidelines can be found here: diagnosis and treatment of pulmonary hypertension PAH ** the requirement to use a validated risk stratification tool to determine ins Determining insufficient response in children does not require use of a validat currently no such validated tools exist for PAH risk stratification in children.	ufficient response applies to adults.

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:

### sildenafil (Vedafil)

0	Patient has Raynaud's phenomenon
and	Patient has severe digital ischaemia (defined as severe pain requiring hospital admission or with a high likelihood of digital ulceration; digital ulcers; or gangrene)
and	Patient is following lifestyle management (proper body insulation, avoidance of cold exposure, smoking cessation support, avoidance of sympathomimetic drugs)
and	Patient has persisting severe symptoms despite treatment with calcium channel blockers and nitrates (unless contraindicated or not tolerated)

O Prescribed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and				
	and	O Patient has pulmonary arterial hypertension (PAH)*		
	(	Э ғ	PAH is	in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications
	and	ЭF	PAH is	in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
	and			
			and	O PAH is confirmed by right heart catheterisation
			(	O A mean pulmonary artery pressure (PAPm) of greater than 20 mmHg
			and	O A pulmonary capillary wedge pressure (PCWP) that is less than or equal to 15 mmHg
			and	$ m O$ Pulmonary vascular resistance (PVR) of at least 2 Wood Units or at least 160 International Units (dyn s cm $^{-5}$ )
			anu	PAH is non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †
				Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**
				O Patient has PAH other than idiopathic / heritable or drug-associated type
		or (		Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disease
		or (		Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures

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.

PRES	RESCRIBER PATIENT:				
Name	:		Name:		
Ward:					
silde	nafi	I (Ve	edafil) - continued		
	INITIATION – tablets other conditions Prerequisites (tick boxes where appropriate)				
	or (	0	For use in weaning patients from inhaled nitric oxide		
	or (	0	For perioperative use in cardiac surgery patients For use in intensive care as an alternative to nitric oxide		
	or (	0	For use in the treatment of erectile dysfunction secondary to spinal cord injury in patients being treated in a spinal unit		
			njection (tick boxes where appropriate)		
	( and	0	For use in the treatment of pulmonary hypertension in infants or children being treated in paediatric intensive care units and neonatal intensive care units when the enteral route is not accessible		
			O For perioperative use following cardiac surgery		
		or	O For use in persistent pulmonary hypertension of the newborn (PPHN)		
			O For use in congenital diaphragmatic hernia		

Note: † The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the diagnosis and treatment of pulmonary hypertension PAH \*\* the requirement to use a validated risk stratification tool to determine insufficient response applies to adults. Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where

currently no such validated tools exist for PAH risk stratification in children.

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:

### Epoprostenol

Re-a	ssess	smen	AH dual therapy required after 6 months ick boxes where appropriate)
( and	á		ibed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of ratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ al.
		Ο	Patient has pulmonary arterial hypertension (PAH)
	and	Ο	PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications
	and and	Ο	PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class III or IV
			O PAH has been confirmed by right heart catheterisation
			A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)
			A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg
			A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm <sup>-5</sup> ) and
			PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †
			O Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**
			O Patient has PAH other than idiopathic / heritable or drug-associated type
		or or	<ul> <li>Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease</li> <li>Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures</li> </ul>
	and		
		an	O Epoprostenol is to be used as part of PAH dual therapy with either sildenafil or an endothelin receptor antagonist
		an	O Patient is presenting in NYHA/WHO functional class IV
		an	O Patient has tried a PAH monotherapy for at least three months and remains in an unacceptable risk category according to a validated risk stratification tool

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:
Epoprosteno	- continued
INITIATION – PA Re-assessment Prerequisites (t O Prescri a respi Hospita and O F and O F	AH triple therapy required after 6 months ick boxes where appropriate) ibed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of ratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
or or and and	<ul> <li>Patient has PAH other than idiopathic / heritable or drug-associated type</li> <li>Patient has palliated single ventricle congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease</li> <li>Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures</li> <li>Epoprostenol is to be used as PAH triple therapy</li> <li>Patient is on the lung transplant list</li> <li>Patient is presenting in NYHA/WHO functional class IV</li> <li>Patient has tried PAH dual therapy for at least three months and has not experienced an acceptable response to treatment according to a validated risk stratification tool</li> <li>Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario</li> </ul>

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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.

PRESCR	IBER	PATIENT:	
Name:		Name:	
Ward:		NHI:	
Epopro	stenol - continued		
	UATION ssment required after 2 years isites (tick box where appropriate)		
and		gist, rheumatologist or any relevant practitioner on the recommendation of nce with a protocol or guideline that has been endorsed by the Health NZ	
	Patient is continuing to derive benefit from epoprostenol treatment a	ccording to a validated PAH risk stratification tool	

Note: † The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines fo	or the
diagnosis and treatment of pulmonary hypertension PAH	
** the requirement to use a validated risk stratification tool to determine insufficient response applies to ac	dults.
Determining insufficient response in children does not require use of a validated PAH risk stratification tool, w	here
currently no such validated tools exist for PAH risk stratification in children.	

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.

PRESCRIE	BER	P	ATIENT:
Name:		N	ame:
Vard:		N	HI:
oprost			
INITIATIO Re-assess Prerequis	DN – P sment sites ( Presc a resp Hospi	piratory specialist, cardiologist or rheumatologist, or in accordance ital. Patient has pulmonary arterial hypertension (PAH) PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical class PAH is in New York Heart Association/World Health Organization O PAH has been confirmed by right heart catheterisatic and O A mean pulmonary artery pressure (PAPm) greater t and O A pulmonary capillary wedge pressure (PCWP) less and O A pulmonary vascular resistance greater than 2 Woo and O PAH has been demonstrated to be non-respon defined in the 2022 ECS/ERS Guidelines for P O Patient has not experienced an acceptable res risk stratification tool** O Patient has PAH other than idiopathic / heritable	n (NYHA/WHO) functional class II, III or IV nn han 20 mmHg (unless peri Fontan repair) than or equal to 15 mmHg d Units or greater than 160 International Units (dyn s cm <sup>-5</sup> ) sive in vasoreactivity assessment using iloprost or nitric oxide, as AH (see note below for link to these guidelines) † ponse to calcium antagonist treatment, according to a validated
and	or	disorders including severe chronic neonatal lung disease O Patient has palliated single ventricle congenital heart disea Fontan circulation requiring the minimising of pulmonary/ve	se and elevated pulmonary pressures or a major complication of the enous filling pressures
and	• 	O Iloprost is to be used as PAH monotherapy	
	and		Idenafil and both the funded endothelin receptor antagonists (i.e.

Patient has an absolute contraindication to sildenafil and an absolute or relative contraindication to endothelin receptor antagonists

or

 $\bigcirc$ 

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: Na				Name:
Ward:				NHI:
llopr	ost - c	contii	nued	
Re-a	ssessm equisite D Pre a re	ent r es (ti escril espir spita	equin ck bo bed k atory II.	red after 6 months oxes where appropriate) by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of or specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ of the has pulmonary arterial hypertension (PAH)
	С	) Р	AH is	s in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications
	and C and	) Р	AH is	s in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
		or ( or (	С	<ul> <li>A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)</li> <li>A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg</li> <li>A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm<sup>-5</sup>)</li> </ul>
	and	( and	Or	<ul> <li>Iloprost is to be used as PAH dual therapy with either sildenafil or an endothelin receptor antagonist</li> <li>Patient has an absolute contraindication to or has experienced intolerable side effects on sildenafil</li> <li>Patient has an absolute or relative contraindication to or experienced intolerable side effects with a funded endothelin receptor antagonist</li> </ul>
	Ĩ	and	or	<ul> <li>Patient has tried a PAH monotherapy for at least three months and remains in an unacceptable risk category according to a validated risk stratification tool**</li> <li>Patient is presenting in NYHA/WHO functional class III or IV, and in the opinion of the treating clinician would benefit from initial dual therapy</li> </ul>

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.

PRES	CRIB	ER				PATIENT:
Name	Name: Name:					
Ward:						NHI:
llopr	ost -	conti	inued			
INITI Re-a	ATION ssessi equisi P a	h - PA ment tes (t rescri respi lospita	AH trij requin ick bo ibed b ratory al. Patient PAH is	ed a xes y, or spe t has in (	Fifter 6 wher r recc cialis s pulr A roup A rr A p A p	<b>py</b> imonths         e appropriate)         mmended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of t, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ         nonary arterial hypertension (PAH)         ot 1, 4 or 5 of the WHO (Venice 2003) clinical classifications         York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV         I has been confirmed by right heart catheterisation         nean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)         ulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg         ulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm <sup>-5</sup> )         PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †         Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**         Patient has PAH other than idiopathic / heritable or drug-associated type
	and	or or and		disor Patie Font	rders ant ha an cin ost is Pat Pat	a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung including severe chronic neonatal lung disease and elevated pulmonary pressures or a major complication of the culation requiring the minimising of pulmonary/venous filling pressures to be used as PAH triple therapy ent is on the lung transplant list ent is presenting in NYHA/WHO functional class IV Patient has tried PAH dual therapy for at least three months and has not experienced an acceptable response to treatment according to a validated risk stratification tool**
						Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario

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.

PRESCR	BER	PATIENT:				
Name:		Name:				
Ward:		NHI:				
lloprost	- continued					
	UATION ssment required after 2 years isites (tick box where appropriate)					
O Prescribed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.						
and	Patient is continuing to derive benefit from iloprost treatment according to a validated PAH risk stratification tool					

Note: † The European Respiratory Journal Guidelines can be found here: <u>2022 ECS/ERS Guidelines for the diagnosis and treatment of pulmonary hypertension PAH</u> \*\* the requirement to use a validated risk stratification tool to determine insufficient response applies to adults. Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

### Dermatologicals

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:			
Mafenide acetate				
INITIATION Prerequisites (tick box where appropriate)				
O For the treatment of burns patients				

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.

PRESCRIBE	3	PATIENT:		
Name:		Name:		
Ward:		NHI:		
Betametha	sone valerate with clioquinol			
INITIATION Prerequisites	<b>s</b> (tick boxes where appropriate)			
	For the treatment of intertrigo			
or O	For continuation use			

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:
Pimecrolimus	

Prer	equisites	(tick boxes where appropriate)
( and		cribed by, or recommended by a dermatologist, paediatrician or ophthalmologist, or in accordance with a protocol or guideline that has been rsed by the Health NZ Hospital.
	O	Patient has atopic dermatitis on the eyelid
		Patient has at least one of the following contraindications to topical corticosteroids: periorificial dermatitis, rosacea, documented epidermal atrophy, documented allergy to topical corticosteroids, cataracts, glaucoma, or raised intraocular pressure

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:
Ta ana lina an Oin Incan I	

### Tacrolimus Ointment

(

### INITIATION

and

Prerequisites (tick boxes where appropriate)

()Prescribed by, or recommended by a dermatologist or paediatrician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

 $\bigcirc$ Patient has atopic dermatitis on the face and

Patient has at least one of the following contraindications to topical corticosteroids: periorificial dermatitis, rosacea, documented epidermal atrophy or documented allergy to topical corticosteroids

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:
Methyl aminolevulinate hydrochloride	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a dermatologist or plastic surgeon, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

### Genito-Urinary System

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:
Terbutaline	

Prerequisites (tick box where appropriate)

()Prescribed by, or recommended by an obstetrician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

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.

PRES	CRIBI	ER		PATIENT:
Name:	:			Name:
Ward:				NHI:
Finas	sterio	de		
INITI/ Prere			tick boxes where appropriate)	
	( and	С	Patient has symptomatic benign prostatic hyperplasia	
			$O\ $ The patient is intolerant of non-selective alpha blockers $a$	or these are contraindicated
		or	O Symptoms are not adequately controlled with non-select	tive alpha blockers

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:
Tamsulosin	
INITIATION           Prerequisites (tick boxes where appropriate)	
O Patient has symptomatic benign prostatic hyperplasia	
The patient is intolerant of non-selective alpha blockers or the	ese are contraindicated

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:
Potassium citrate	
INITIATION           Prerequisites (tick boxes where appropriate)	
O The patient has recurrent calcium oxalate urolithiasis	
O The patient has had more than two renal calculi in the two yes	ars prior to the application

### Hormone Preparations

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:
Oxandrolone - Tab 2.5 mg	
INITIATION Prerequisites (tick box where appropriate)	
O For the treatment of burns patients	

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.

PRESCR	IBER	PATIENT:
Name:		Name:
Ward:		NHI:
Cinacal	cet	
Re-asse	ON – parathyroid carcinoma or calciphylaxis ssment required after 6 months isites (tick boxes where appropriate) Prescribed by, or recommended by a nephrologist or endocrinolog the Health NZ Hospital.	gist, or in accordance with a protocol or guideline that has been endorsed by
	O The patient has been diagnosed with a parathyroid ca and O The patient has persistent hypercalcaemia (serum ca treatments including sodium thiosulfate (where appro and O The patient is symptomatic	lcium greater than or equal to 3 mmol/L) despite previous first-line
or	and	alcific uraemic arteriolopathy) s) hypercalcaemia (serum calcium greater than or equal to 3 mmol/L) s first-line treatments including bisphosphonates and sodium thiosulfate
	UATION – parathyroid carcinoma or calciphylaxis isites (tick boxes where appropriate) Prescribed by, or recommended by a nephrologist or endocrinolog the Health NZ Hospital.	gist, or in accordance with a protocol or guideline that has been endorsed by
an	<ul> <li>The patient's serum calcium level has fallen to &lt; 3mmol/L</li> <li>The patient has experienced clinically significant symptom in the patient has experienced adenomas unless these have been been been been been been been be</li></ul>	
	ON – primary hyperparathyroidism isites (tick boxes where appropriate)	
an an an	or O Patient has hypercalcaemia of more than 3 mmol/L v O Patient has hypercalcaemia of more than 2.85 mmol/ O Surgery is not feasible or has failed	L with symptoms

#### I confirm that the above details are correct:

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

or ()

#### 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.

PRESC	RIBE	R		PATIENT:
Name:				Name:
Ward:				NHI:
Cinaca	alce	t - c	ontinued	
			condary or tertiary hyperparathyroidism equired after 6 months	
			ck boxes where appropriate)	
		(	${\cal O}$ Patient has tertiary hyperparathyroidism and markedly e	levated parathyroid hormone (PTH) with hypercalcaemia
		or (	O Patient has symptomatic secondary hyperparathyroidisn	n and elevated PTH

Residual parathyroid tissue has not been localised despite repeat unsuccessful parathyroid explorations
Parathyroid tissue is surgically inaccessible
Parathyroid surgery is not feasible
condary or tertiary hyperparathyroidism
ed after 12 months xes where appropriate)
ed at

hormone (PTH) level to support ongoing cessation of treatment has not been reached

The patient has not received a kidney transplant and trial of withdrawal of cinacalcet is clinically inappropriate

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:
Cabergoline	
INITIATION Prerequisites (tick boxes where appropriate)	
O Inhibition of lactation	
O Patient has hyperprolactinemia	
O Patient has acromegaly	
Note: Indication marked with * is an unapproved indication.	

RS1826 - Somatropin	
Prader-Willi syndrome - INITIATION	126
Prader-Willi syndrome - CONTINUATION	126
Turner syndrome - INITIATION	123
Turner syndrome - CONTINUATION	124
Adults and adolescents - INITIATION	127
Adults and adolescents - CONTINUATION	
Growth hormone deficiency in children - INITIATION	123
Growth hormone deficiency in children - CONTINUATION	123
Short stature due to chronic renal insufficiency - INITIATION	125
Short stature due to chronic renal insufficiency - CONTINUATION	
Short stature without growth hormone deficiency - INITIATION	
Short stature without growth hormone deficiency - CONTINUATION	124

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.

PRES	CRIBER	PATIENT:	
Name	lame: Name:		
Ward:	/ard: NHI:		
Soma	atropin		
INITI Re-as	<ul> <li>ATION – growth hormone deficiency in children ssessment required after 12 months equisites (tick boxes where appropriate)</li> <li>Prescribed by, or recommended by an endocrinologist or paediatric en- endorsed by the Health NZ Hospital.</li> <li>Growth hormone deficiency causing symptomatic hypoglycaemic cardiomyopathy, hepatic dysfunction) and diagnosed with GH &lt; life, or from samples during established hypoglycaemia (whole b or</li> <li>Height velocity &lt; 25th percentile for age; and adjusted for standards of Tanner and Davies (1985) and O A current bone age is &lt; 14 years (female patients) or &lt; 16 and O Peak growth hormone value of &lt; 5.0 mcg per litre in response who are 5 years or older, GH testing with sex steroid primi and O If the patient has been treated for a malignancy, they should other the standards of the patient has been treated for a malignancy, they should other the standards of the patient has been treated for a malignancy, they should other the patient has been treated for a malignancy of the standards of the patient has been treated for a malignancy they should other the patient has been treated for a malignancy they should other the patient has been treated for a malignancy they should other the patient has been treated for a malignancy they should other the patient has been treated for a malignancy they should other the patient has been treated for a malignancy they should other the patient has been treated for a malignancy they should other the patient has been treated for a malignancy they should other the patient has been treated for a malignancy they should other the patient has been treated for a malignancy they should other the patient has been treated for a malignancy the patient of the patient has been treated for a malignancy the patient for the patient has been treated for a malignancy the patient has been treated for a malignancy the patient for the patient has been treated for a malignancy the patient for the patient has been treated for a malignancy the p</li></ul>	bone age/pubertal status if appropriate over 6 or 12 months using the years (male patients) inse to two different growth hormone stimulation tests. In children ng is required Id be disease free for at least one year based upon follow-up lignancy, unless there are strong medical reasons why this is either	
Re-as	TINUATION – growth hormone deficiency in children ssessment required after 12 months equisites (tick boxes where appropriate)		
and	endorsed by the Health NZ Hospital. O A current bone age is 14 years or under (female patients) or 16 and O Height velocity is greater than or equal to 25th percentile for age hormone treatment, as calculated over six months using the star and O Height velocity is greater than or equal to 2.0 cm per year, as ca and	(adjusted for bone age/pubertal status if appropriate) while on growth adards of Tanner and Davis (1985)	
Re-as	ATION – Turner syndrome ssessment required after 12 months equisites (tick boxes where appropriate) Prescribed by, or recommended by an endocrinologist or paediatric en endorsed by the Health NZ Hospital. The patient has a post-natal genotype confirming Turner Syndro and	docrinologist, or in accordance with a protocol or guideline that has been	

O Height velocity is < 25th percentile over 6-12 months using the standards of Tanner and Davies (1985)

O A current bone age is < 14 years

I confirm that the above details are correct:

and

Signed:	Date:
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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:		
Nard: NHI:		
Somatropin - continued		
CONTINUATION – Turner syndrome         Re-assessment required after 12 months         Prerequisites (tick boxes where appropriate)         O       Prescribed by, or recommended by an endocrinologist or paediatric endorsed by the Health NZ Hospital.         and	ndocrinologist, or in accordance with a protocol or guideline that has been	
and endorsed by the Health NZ Hospital. The patient's height is more than 3 standard deviations below th or delay and Height velocity is < 25th percentile for age (adjusted for bone age using the standards of Tanner and Davies(1985) and A current bone age is < 14 years (female patients) or < 16 year and	ndocrinologist, or in accordance with a protocol or guideline that has been he mean for age or for bone age if there is marked growth acceleration ge/pubertal status if appropriate), as calculated over 6 to 12 months rs (male patients) alignancy or recognized severe skeletal dysplasia) and is not receiving	
CONTINUATION – short stature without growth hormone deficiency         Re-assessment required after 12 months         Prerequisites (tick boxes where appropriate)         O       Prescribed by, or recommended by an endocrinologist or paediatric endorsed by the Health NZ Hospital.         and	ndocrinologist, or in accordance with a protocol or guideline that has been	
<ul> <li>Height velocity is greater than or equal to 50th percentile (adjus 12 months using the standards of Tanner and Davies (1985)</li> <li>and</li> <li>Height velocity is greater than or equal to 2 cm per year as calc and</li> <li>Current bone age is 14 years or under (female patients) or 16 yeard</li> </ul>		

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.

PRES	CRIBE	R	PATIENT:
Name	lame: Name:		Name:
Ward			NHI:
Som	atropi	in - continued	
	-	- short stature due to chronic renal insufficiency	
		ent required after 12 months es (tick boxes where appropriate)	
Fier			
and		escribed by, or recommended by an endocrinologist, paediatric er paediatric endocrinologist, or in accordance with a protocol or gui	ndocrinologist or renal physician on the recommendation of a endocrinologist ideline that has been endorsed by the Health NZ Hospital.
	and	) The patient's height is more than 2 standard deviations below	the mean
	C	Height velocity is < 25th percentile (adjusted for bone age/pub standards of Tanner and Davies (1985)	pertal status if appropriate) as calculated over 6 to 12 months using the
	and	A current bone age is to 14 years or under (female patients) o	r to 16 years or under (male patients)
	and	) The patient is metabolically stable, has no evidence of metabolically stable.	olic bone disease and absence of any other severe chronic disease
	and	The patient is under the supervision of a specialist with experi	tise in renal medicine
		O The patient has a GFR less than or equal to 30 ml/min/ creatinine (umol/l × 40 = corrected GFR (ml/min/1.73 m	1.73 m <sup>2</sup> as measured by the Schwartz method (Height(cm)/plasma <sup>2</sup> ) in a child who may or may not be receiving dialysis
		$\sim$	eived < 5mg/ m <sup>2</sup> /day of prednisone or equivalent for at least 6 months
		<b>FION – short stature due to chronic renal insufficiency</b> ent required after 12 months	
		es (tick boxes where appropriate)	
(		escribed by, or recommended by an endocrinologist, paediatric er paediatric endocrinologist, or in accordance with a protocol or gui	ndocrinologist or renal physician on the recommendation of a endocrinologist ideline that has been endorsed by the Health NZ Hospital.
and			
	C	Height velocity is greater than or equal to 50th percentile (adjulation 12 months using the standards of Tanner and Davies (1985)	usted for bone age/pubertal status if appropriate) as calculated over 6 to
	and	Height velocity is greater than or equal to 2 cm per year as ca	Iculated over six months
	and	A current bone age is 14 years or under (female patients) or 1	6 years or under (male patients)
	and	No serious adverse effect that the patients specialist consider	s is likely to be attributable to growth hormone has occurred
	and	No malignancy has developed after growth hormone therapy	was commenced
	and	The patient has not experienced significant biochemical or me	etabolic deterioration confirmed by diagnostic results
	and	The patient has not received renal transplantation since starting	ng growth hormone treatment
	and	If the patient requires transplantation, growth hormone prescribe made after transplantation based on the above criteria	ption should cease before transplantation and a new application should

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:	me: Name:		
Ward:			
Somatropin	- continued		
Re-assessmer Prerequisites O Pres	Prader-Willi syndrome tt required after 12 months (tick boxes where appropriate) cribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been irsed by the Health NZ Hospital.		
and and	The patient has a diagnosis of Prader-Willi syndrome that has been confirmed by genetic testing or clinical scoring criteria The patient is aged six months or older		
and	A current bone age is < 14 years (female patients) or < 16 years (male patients) Sleep studies or overnight oximetry have been performed and there is no obstructive sleep disorder requiring treatment, or if an obstructive sleep disorder is found, it has been adequately treated under the care of a paediatric respiratory physician and/or ENT surgeon		
or	<ul> <li>O The patient is aged two years or older</li> <li>and</li> <li>O There is no evidence of type II diabetes or uncontrolled obesity defined by BMI that has increased by greater than or equal to 0.5 standard deviations in the preceding 12 months</li> <li>O The patient is aged between six months and two years and a thorough upper airway assessment is planned to be undertaken prior to treatment commencement and at six to 12 weeks following treatment initiation</li> </ul>		
Re-assessmer Prerequisites O Pres	DN – Prader-Willi syndrome ht required after 12 months (tick boxes where appropriate) cribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been prised by the Health NZ Hospital.		
and O and O	Height velocity is greater than or equal to 50th percentile (adjusted for bone age/pubertal status if appropriate) as calculated over 6 to 12 months using the standards of Tanner and Davies (1985)		
and and	Height velocity is greater than or equal to 2 cm per year as calculated over six months A current bone age is 14 years or under (female patients) or 16 years or under (male patients)		
and and	No serious adverse effect that the patient's specialist con siders is likely to be attributable to growth hormone treatment has occurred No malignancy has developed after growth hormone therapy was commenced The patient has not developed type II diabetes or uncontrolled obesity as defined by BMI that has increased by greater than or equal		
	to 0.5 standard deviations in the preceding 12 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:
Soma	atro	pin	- continued	
Re-as	ssess	smen	dults and adolescents t required after 12 months (tick boxes where appropriate)	
and			ribed by, or recommended by an endocrinologist or paediatric or sed by the Health NZ Hospital.	endocrinologist, or in accordance with a protocol or guideline that has been
	and		The patient has a medical condition that is known to cause gro treatment of a pituitary tumour)	wth hormone deficiency (e.g. surgical removal of the pituitary for
		Ο	The patient has undergone appropriate treatment of other horn	nonal deficiencies and psychological illnesses
	and and	Ο	The patient has severe growth hormone deficiency (see notes)	
	and	Ο	The patient's serum IGF-I is more than 1 standard deviation be	slow the mean for age and sex
	ana	0	The patient has poor quality of life, as defined by a score of 16 growth hormone deficiency (QoL-AGHDA®)	or more using the disease-specific quality of life questionnaire for adult
equal Patie	to 3 nts w	mcg /ith or	per litre during an adequately performed insulin tolerance test ne or more additional anterior pituitary hormone deficiencies an	ficiency is defined as a peak serum growth hormone level of less than or (ITT) or glucagon stimulation test. d a known structural pituitary lesion only require one test. Patients with sts, of which, one should be ITT unless otherwise contraindicated. Where

isolated growth hormone deficiency require two growth hormone stimulation tests, of which, one should be ITT unless otherwise contraindicated. Where an additional test is required, an arginine provocation test can be used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre. The dose of somatropin should be started at 0.2 mg daily and be titrated by 0.1 mg monthly until it is within 1 standard deviation of the mean normal value for age and sex; and

The dose of somatropin not to exceed 0.7 mg per day for male patients, or 1 mg per day for female patients.

At the commencement of treatment for hypopituitarism, patients must be monitored for any required adjustment in replacement doses of corticosteroid and levothyroxine.

I confirm that the above details are correc	t:
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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.	

PRES	CRIE	CRIBER PATIENT:		
Name:	:	Name:		
Ward:			NHI:	
Soma	atro	pin - con	tinued	
Re-as	ssess equis D F	sment requ i <b>ites</b> (tick b Prescribed	dults and adolescents ired after 12 months ioxes where appropriate) by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been by the Health NZ Hospital.	
anu		and and	The patient has been treated with somatropin for < 12 months There has been an improvement in the Quality of Life Assessment defined as a reduction of at least 8 points on the Quality of Life Assessment of Growth Hormone Deficiency in Adults (QoL-AGHDA®) score from baseline	
		and	Serum IGF-I levels have increased to within ±1SD of the mean of the normal range for age and sex The dose of somatropin does not exceed 0.7 mg per day for male patients, or 1 mg per day for female patients	
	or			
		and and and and	The patient has been treated with somatropin for more than 12 months The patient has not had a deterioration in Quality of Life defined as a 6 point or greater increase from their lowest QoL-AGHDA® score on treatment (other than due to obvious external factors such as external stressors) Serum IGF-I levels have continued to be maintained within ±1SD of the mean of the normal range for age and sex (other than for obvious external factors) The dose of somatropin has not exceeded 0.7 mg per day for male patients or 1 mg per day for female patients	
	or			
		and and and	The patient has had a Special Authority approval for somatropin for childhood deficiency in children and no longer meets the renewal criteria under this indication The patient has undergone appropriate treatment of other hormonal deficiencies and psychological illnesses The patient has severe growth hormone deficiency (see notes)	
		and and and	The patient's serum IGF-I is more than 1 standard deviation below the mean for age and sex	
			The patient has poor quality of life, as defined by a score of 16 or more using the disease-specific quality of life questionnaire for adult growth hormone deficiency (QoL-AGHDA®)	
equal	l to 3	mcg per lit	ses of adults and adolescents, severe growth hormone deficiency is defined as a peak serum growth hormone level of less than or irre during an adequately performed insulin tolerance test (ITT) or glucagon stimulation test. more additional anterior pituitary hormone deficiencies and a known structural pituitary lesion only require one test. Patients with	

isolated growth hormone deficiency require two growth hormone stimulation tests, of which, one should be ITT unless otherwise contraindicated. Where an additional test is required, an arginine provocation test can be used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre. The dose of somatropin should be started at 0.2 mg daily and be titrated by 0.1 mg monthly until the serum IGF-I is within 1 standard deviation of the mean normal value for age and sex; and

The dose of somatropin not to exceed 0.7 mg per day for male patients, or 1 mg per day for female patients.

At the commencement of treatment for hypopituitarism, patients must be monitored for any required adjustment in replacement doses of corticosteroid and levothyroxine.

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:
Liothyronine sodium - Tab 20 mcg	

Prerequisites (tick box where appropriate)

m O~ For a maximum of 14 days' treatment in patients with thyroid cancer who are due to receive radioiodine therapy

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:
Propylthiouracil	
INITIATION Prerequisites (tick boxes where appropriate)	
O The patient has hyperthyroidism	
The patient is intolerant of carbimazole or carbimazole is co	ntraindicated

Infections

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:
Streptomycin sulphate	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Amikacin	

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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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:
Tobramycin	

### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Tobramycin Solution for inhalation 60 mg per ml, 5 ml	
INITIATION Prerequisites (tick box where appropriate)	
O Patient has cystic fibrosis	

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:
Tobramcyin	
INITIATION Prerequisites (tick box where appropriate)	
O For addition to orthopaedic bone cement	

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:
Paromomycin	

### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or gastroenterologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Imipenem with cilastatin	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Ertapenem	

### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Meropenem	

### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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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:
Ceftazidime with avibactam	

requisite	es (	(tick boxes where appropriate)
and		Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital
		O Proven infection with a carbapenem-resistant micro-organism, based on microbiology report
	or	O Probable infection with a carbapenem-resistant micro-organism, based on assessment by a clinical microbiologist or infectious disease specialist.

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:				
Ceftazadime					

### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:				
Cefepime					

### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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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.

PRES	SCRIBER	PATIENT:					
Name	2	Name:					
Ward		NHI:					
Ceftaroline							
INITIATION – multi-resistant organisn salvage therapy         Prerequisites (tick boxes where appropriate)         O       Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has							
and	been endorsed by the Health NZ Hospital.						
	O For patients where alternative therapies have failed or $O$ For patients who have a contraindication or hypersensitivity to	standard surrout therapies					
	• To patients who have a contraindication of hypersensitivity to	standard current merapies					

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:
Roxithromycin tab dispersible 50 mg	
INITIATION Prerequisites (tick box where appropriate)	
O Only for use in patients under 12 years of age	

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:	
Clarithromycin		
INITIATION – Tab 250 mg and oral liquid         Prerequisites (tick boxes where appropriate)         O       Atypical mycobacterial infection         or       O         or       Helicobacter pylori eradication	stance or intolerance to standard pharmaceutical agents	
O Prophylaxis of infective endocarditis associated with surgical of	or dental procedures if amoxicillin is contra-indicated	
INITIATION – Tab 500 mg         Prerequisites (tick box where appropriate)         O       Helicobacter pylori eradication		
INITIATION – Infusion Prerequisites (tick boxes where appropriate)		

or O Mycobacterium tuberculosis infection where there is drug resistance or intolerance to standard pharmaceutical agents

O Community-acquired pneumonia

Atypical mycobacterial infection

 $\bigcirc$ 

or

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:	
Azithromycin		
INITIATION – bronchiolitis obliterans syndrome, cystic fibrosis and atyp Prerequisites (tick boxes where appropriate)	ical Mycobacterium infections	
<ul> <li>Patient has received a lung transplant, stem cell transplant or bone marrow transplant and requires treatment for bronchiolitis obliterans syndrome*</li> <li>Patient has received a lung transplant and requires prophylaxis for bronchiolitis obliterans syndrome*</li> <li>Patient has cystic fibrosis and has chronic infection with Pseudomonas aeruginosa or Pseudomonas related gram negative organisms*</li> <li>Patient has an atypical Mycobacterium infection</li> <li>Note: Indications marked with * are unapproved indications</li> </ul>		
INITIATION – non-cystic fibrosis bronchiectasis* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a respiratory specialist or paediatrician, or in accordance with a protocol or guideline that has been		
and endorsed by the Health NZ Hospital. O For prophylaxis of exacerbations of non-cystic fibrosis bronch and O Patient is aged 18 and under and O Patient has had 3 or more exacerbations of their bronch or O Patient has had 3 acute admissions to hospital for treate		
Note: Indications marked with * are unapproved indications. A maximum of 24 months of azithromycin treatment for non-cystic fibrosis will be subsidised in the community.		
CONTINUATION – non-cystic fibrosis bronchiectasis* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a respiratory specialist or paedia endorsed by the Health NZ Hospital. and O The patient has completed 12 months of azithromycin treatment and O Following initial 12 months of treatment, the patient has not re-		
and The patient will not receive more than a total of 24 months' az Note: Indications marked with * are unapproved indications. A maximum of 2 in the community.	ically inappropriate to stop treatment ithromycin cumulative treatment (see note)	
INITIATION – other indications Re-assessment required after 5 days Prerequisites (tick box where appropriate)		

O For any other condition

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:	Name:
Ward:	NHI:
Azithromycin - continued	
CONTINUATION – other indications Re-assessment required after 5 days Prerequisites (tick box where appropriate)	
O For any other condition	

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:	
Ticarcillin with clavulanic acid		

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	
Piperacillin with tazobactam		

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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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:
Ciprofloxacin	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:

#### Moxifloxacin

		DN – Mycobacterium infection sites (tick boxes where appropriate)
and		Prescribed by, or recommended by an infectious disease specialist, clinical microbiologist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
		Active tuberculosis
		O Documented resistance to one or more first-line medications or O Suspected resistance to one or more first-line medications (tuberculosis assumed to be contracted in an area with nor O the second-line agents
		or O Significant pre-existing liver disease or hepatotoxicity from tuberculosis medications
		O Significant documented intolerance and/or side effects following a reasonable trial of first-line medications
	or or	<ul> <li>O Mycobacterium avium-intracellulare complex not responding to other therapy or where such therapy is contraindicated</li> <li>O Patient is under five years of age and has had close contact with a confirmed multi-drug resistant tuberculosis case</li> </ul>
	equi:	DN – Pneumonia         sites (tick boxes where appropriate)         Prescribed by, or recommended by an infectious disease specialist or clinical microbiologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	or	O Immunocompromised patient with pneumonia that is unresponsive to first-line treatment
		O Pneumococcal pneumonia or other invasive pneumococcal disease highly resistant to other antibiotics
		DN – Penetrating eye injury sites (tick box where appropriate)
and		Prescribed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
anu	0	Five days treatment for patients requiring prophylaxis following a penetrating eye injury
		DN – Mycoplasma genitalium sites (tick boxes where appropriate)
	and	O Has nucleic acid amplification test (NAAT) confirmed Mycoplasma genitalium and is symptomatic
	une	O Has tried and failed to clear infection using azithromycin
		O Has laboratory confirmed azithromycin resistance
	and	d O Treatment is only for 7 days

Signed:		Date:	
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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:		
Moxifloxacin - continued			
INITIATION – severe delayed beta-lactam allergy           Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by an infectious disease specialist or clinical microbiologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			

O Individual has a history of severe delayed beta-lactam allergy

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:
Tigecycline	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Daptomycin	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Lincomycin	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Linezolid	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Sulphadiazine	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or maternal-foetal medicine specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Teicoplanin	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Fosfomycin	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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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:
Pivmecillinam	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Vancomycin	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Aztreonam, Chloramphenicol	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Clindamycin	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Fusidic acid	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:		
Colistin sulphomethate [Colestimethate]			

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	
Ketoconazole - Tab 200 mg		

#### INITIATION

Prerequisites (tick box where appropriate)

()Prescribed by, or recommended by an oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

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:	

### Amphotericin B - Inj (liposomal) 50 mg vial

### INITIATION

and

and

Prerequisites (tick boxes where appropriate) ( ) Prescribed by, or recommended by a clinical microbiologist, haematologist, infectious disease specialist, oncologist, respiratory specialist or transplant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

	$\bigcirc$	Proven or probable invasive fungal infection, to be prescribed under an established protocol	
or			

()Possible invasive fungal infection

A multidisciplinary team (including an infectious disease physician or a clinical microbiologist) considers the treatment to be () appropriate

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:	
Amphotericin B - Inj 50 mg vial		

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, haematologist, infectious disease specialist, oncologist, respiratory specialist or transplant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	
Fluconazole		

#### INITIATION

Prerequisites (tick box where appropriate)

()Prescribed by, or recommended by a consultant, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

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:
Itraconazole	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical immunologist, clinical microbiologist, dermatologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

July 2023	)	RESTRICTION	5 CHECKLIST
		st to determine if a patient meets the restrictions for funding in th ommunity funding, see the Special Authority Criteria.	e hospital setting. For more details, refer to Section H of the Pharmaceutical
PRESCR	IBER		PATIENT:
Name:			Name:
Ward:			NHI:
Voricon	nazole	e	
		Proven or probable aspergillus infection (tick boxes where appropriate)	
O and		cribed by, or recommended by a clinical microbiologist, haemato line that has been endorsed by the Health NZ Hospital.	ologist or infectious disease specialist, or in accordance with a protocol or
an		Patient is immunocompromised	
	$\sim$	Patient has proven or probable invasive aspergillus infection	
		Possible aspergillus infection (tick boxes where appropriate)	
and		cribed by, or recommended by a clinical microbiologist, haemato line that has been endorsed by the Health NZ Hospital.	ologist or infectious disease specialist, or in accordance with a protocol or
	-	Patient is immunocompromised	
O Patient has possible invasive aspergillus infection			
an	$\sim$	A multidisciplinary team (including an infectious disease physic	cian) considers the treatment to be appropriate
		Resistant candidiasis infections and other moulds (tick boxes where appropriate)	
O		cribed by, or recommended by a clinical microbiologist, haemato line that has been endorsed by the Health NZ Hospital.	ologist or infectious disease specialist, or in accordance with a protocol or
an	-	Patient is immunocompromised	
		O Patient has fluconazole resistant candidiasis	
	or	O Patient has mould strain such as Fusarium spp. and Sce	edosporium spp
an	$\sim$	A multidisciplinary team (including an infectious disease physic	cian or clinical microbiologist) considers the treatment to be appropriate
Re-asses	ssment	nvasive fungal infection prophylaxis t required after 6 months (tick boxes where appropriate)	
O and		cribed by, or recommended by any relevant practitioner, or in accospital.	cordance with a protocol or guideline that has been endorsed by the Health
an	-	The patient is at risk of invasive fungal infection	
all	or	O Voriconazole is prescribed by, or recommended by a have paediatric haematologist or paediatric oncologist	ematologist, transplant physician, infectious disease specialist,
			I or guideline that has been endorsed by the Health New Zealand - Te s a greater than 10% risk of invasive fungal infection (IFI)

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.

r the Health		
and O The patient is at risk of invasive fungal infection		
d - Te		

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:
D	

### Posaconazole

INITIATION Re-assessment required after 6 weeks
Prerequisites (tick boxes where appropriate)
O Prescribed by, or recommended by a haematologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
O Patient has acute myeloid leukaemia or
O Patient is planned to receive a stem cell transplant and is at high risk for aspergillus infection
Patient is to be treated with high dose remission induction therapy or re-induction therapy
CONTINUATION Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate)
O Prescribed by, or recommended by a haematologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
Patient has previously received posaconazole prophylaxis during remission induction therapy
O Patient is to be treated with high dose remission re-induction therapy or
O Patient is to be treated with high dose consolidation therapy or
O Patient is receiving a high risk stem cell transplant
INITIATION – Invasive fungal infection prophylaxis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)
O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
The patient is at risk of invasive fungal infection
O Posaconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease specialist, paediatric haematologist or paediatric oncologist
Prescribing posaconazole is in accordance with a protocol or guideline that has been endorsed by the Health New Zealand - Te Whatu Ora Hospital in the specific settings where there is a greater than 10% risk of invasive fungal infection (IFI)

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.

PRES	CRIB	BER			PATIENT:
Name	:				Name:
Ward:					NHI:
Posa	con	azo	le - a	continued	
Re-as	ssess equis D F	i <b>tes</b> Presc	t requ (tick b		cordance with a protocol or guideline that has been endorsed by the Health
	and	Ο	The p	patient is at risk of invasive fungal infection	
		or	ł	Posaconazole is prescribed by, or recommended by a hap paediatric haematologist or paediatric oncologist	ematologist, transplant physician, infectious disease specialist,
			0		ol or guideline that has been endorsed by the Health New Zealand - Te s a greater than 10% risk of invasive fungal infection (IFI)

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:	
Flucytosine		

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:		
Caspofungin			

### 

Prerequisites (tick boxes where appropriate)				
and	С	Prescribed by, or recommended by a clinical microbiologist, haematologist, infectious disease specialist, oncologist, respiratory specialist or transplant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
	O Proven or probable invasive fungal infection, to be prescribed under an established protocol or			
		and	Possible invasive fungal infection	
		0	A multidisciplinary team (including an infectious disease physician or a clinical microbiologist) considers the treatment to be appropriate	

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:	
Clofazimine		

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, dermatologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	
Dapsone		

### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, dermatologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Cycloserine	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Isoniazid with rifampicin	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, dermatologist, paediatrician, public health physician or internal medicine physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Pyrazinamide	

### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Rifampicin	

### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, dermatologist, internal medicine physician, paediatrician or public health physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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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.

PATIENT:
Name:
NHI:
ed the individual case and recommends bedaquiline as part of the

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:
Isoniazid	

### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, dermatologist, paediatrician, public health physician or internal medicine physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Rifabutin	

### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, gastroenterologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Ethambutol hydrochloride	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Para-aminosalicylic Acid	

### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Protionamide	

### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Albendazole	

### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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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:
Ivermectin	

### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, dermatologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Artemether with lumefantrine	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Artesunate	

### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Atovaquone with proguanil hydrochloride	

### INITIATION

#### Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Chloroquine phosphate	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, dermatologist, infectious disease specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Mefloquine hydrochloride	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, dermatologist, infectious disease specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Pentamidine isethionate	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Primaguine phosphate	

### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Pyrimethamine	

### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or maternal-foetal medicine specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Quinine dihydrochloride	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Sodium stibogluconate	

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Spiramycin	

### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a maternal-foetal medicine specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Nitazoxanide	

### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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	ł	PATIENT:
Name:		Name:
Ward:		NHI:
Non-Nucleo	oside Reverse Transcriptase Inhibitors	
	Confirmed HIV s (tick box where appropriate)	
O Pati	ent has confirmed HIV infection	
	Prevention of maternal transmission s (tick boxes where appropriate)	
or O	Prevention of maternal foetal transmission Treatment of the newborn for up to eight weeks	
	Post-exposure prophylaxis following exposure to HIV s (tick boxes where appropriate) Treatment course to be initiated within 72 hours post exposu	Jre
	unknown or detectable viral load greater than 200 cop	tive vaginal intercourse with a known HIV positive person with an ies per ml
O	O Patient has had non-consensual intercourse and the c required	th a known HIV positive person
O	$\hat{}$	erson from a high HIV prevalence country or risk group whose HIV status
Note: Refer to	o local health pathways or the Australasian Society for HIV, Vir	al Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.ashn
Prerequisites	Percutaneous exposure s (tick box where appropriate) ent has percutaneous exposure to blood known to be HIV posi	tive

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:			Name:
Ward:				NHI:
Nucleosi	de F	Reve	rse Transcriptase Inhibitors	
INITIATION Prerequisi			med HIV ox where appropriate)	
Ор	atien	t has	confirmed HIV infection	
			ntion of maternal transmission oxes where appropriate)	
or (			ention of maternal foetal transmission ment of the newborn for up to eight weeks	
Prerequisi	ites (	tick b	xposure prophylaxis following exposure to HIV oxes where appropriate) ment course to be initiated within 72 hours post exposur	e
and	or	0	Patient has had condomless anal intercourse or reception unknown or detectable viral load greater than 200 copie	ve vaginal intercourse with a known HIV positive person with an is per ml
	or	0 0		a known HIV positive person nician considers that the risk assessment indicates prophylaxis is
	or	0	required Patient has had condomless anal intercourse with a per is unknown	son from a high HIV prevalence country or risk group whose HIV status
Note: Refe	er to l	ocal	nealth pathways or the Australasian Society for HIV, Viral	Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.ashn
Prerequisi	tes (	tick b	aneous exposure ox where appropriate) percutaneous exposure to blood known to be HIV positi	ve

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.

PRESCR	IBER			PATIENT:
Name:				Name:
Ward:				NHI:
Proteas	se Inł	nibit	ors	
			rmed HIV pox where appropriate)	
0	Patie	nt has	s confirmed HIV infection	
			ntion of maternal transmission boxes where appropriate)	
or	0 0		ention of maternal foetal transmission tment of the newborn for up to eight weeks	
			exposure prophylaxis following exposure to HIV poxes where appropriate)	
an	d	Trea	tment course to be initiated within 72 hours post exposur	e
		0	Patient has had condomless anal intercourse or reception unknown or detectable viral load greater than 200 copies	ve vaginal intercourse with a known HIV positive person with an s per ml
	or	Ο	Patient has shared intravenous injecting equipment with	a known HIV positive person
	or	0	Patient has had non-consensual intercourse and the clin required	nician considers that the risk assessment indicates prophylaxis is
	or	0	Patient has had condomless anal intercourse with a per is unknown	son from a high HIV prevalence country or risk group whose HIV status
Note: Re	efer to	local	health pathways or the Australasian Society for HIV, Viral	Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.ash
	isites	(tick I	taneous exposure box where appropriate) s percutaneous exposure to blood known to be HIV positi	/e

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.

RESCRIBER	1	PATIENT:
lame:		Name:
Vard:		NHI:
strand Trar	nsfer Inhibitors	
	Confirmed HIV s (tick box where appropriate)	
O Pati	ent has confirmed HIV infection	
	Prevention of maternal transmission s (tick boxes where appropriate)	
or O	Prevention of maternal foetal transmission Treatment of the newborn for up to eight weeks	
Prerequisites	Post-exposure prophylaxis following exposure to HIV s (tick boxes where appropriate) Treatment course to be initiated within 72 hours post expos	ure
and	unknown or detectable viral load greater than 200 cor	ptive vaginal intercourse with a known HIV positive person with an bies per ml
0	O Patient has had non-consensual intercourse and the required	ith a known HIV positive person
0	$\sim$	erson from a high HIV prevalence country or risk group whose HIV status
Note: Refer to	o local health pathways or the Australasian Society for HIV, Vi	ral Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.asl
Prerequisites	Percutaneous exposure s (tick box where appropriate) ent has percutaneous exposure to blood known to be HIV pos	itive

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:

### Ledipasvir with sofosbuvir

Note: Only for use in patients with approval by the Hepatitis C Treatment Panel (HepCTP). Applications will be considered by HepCTP at its regular meetings and approved subject to eligibility according to the Access Criteria (set out in Section B of the Pharmaceutical Schedule).

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:
Cidofovir	

### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist, otolaryngologist or oral surgeon, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:		
Foscarnet sodium			

#### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:			
Ganciclovir				

### INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

		list to determine if a patient meets the restrictions for funding community funding, see the Special Authority Criteria.	in the <b>hospital setting</b> . For more details, refer to Section H of the Pharmaceutical
PRES	CRIBER	3	PATIENT:
Name:			Name:
Ward:			NHI:
Valga	nciclo	ovir	
Re-as	sessme quisites	<ul> <li>Transplant cytomegalovirus prophylaxis</li> <li>ent required after 3 months</li> <li>s (tick box where appropriate)</li> <li>ient has undergone a solid organ transplant and requires val</li> </ul>	ganciclovir for CMV prophylaxis
Re-as	sessme	ION – Transplant cytomegalovirus prophylaxis ent required after 3 months s (tick boxes where appropriate)	
	or	CMV prophylaxis Patient is to receive a maximum of 90 days of valga Patient has received pulse methylprednisolone for a prophylaxis	received anti-thymocyte globulin and requires valganciclovir therapy for inciclovir prophylaxis following anti-thymocyte globulin acute rejection and requires further valganciclovir therapy for CMV inciclovir prophylaxis following pulse methylprednisolone
Re-as	sessme quisites ) Pres	<ul> <li>Lung transplant cytomegalovirus prophylaxis ent required after 12 months</li> <li>s (tick boxes where appropriate)</li> <li>scribed by, or recommended by a relevant specialist, or in ac spital.</li> </ul>	ccordance with a protocol or guideline that has been endorsed by the Health NZ
	and or and	<ul> <li>Patient has undergone a lung transplant</li> <li>O The donor was cytomegalovirus positive and the parent of the recipient is cytomegalovirus positive</li> <li>Patient has a high risk of CMV disease</li> </ul>	tient is cytomegalovirus negative
		- Cytomegalovirus in immunocompromised patients s (tick boxes where appropriate)	
	and oi	m O Patient has rapidly rising plasma CMV DNA in abse	

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:
Emtricitabine with tenofovir disoproxil	
INITIATION – Confirmed HIV	
Prerequisites (tick box where appropriate)	
O Patient has confirmed HIV infection	
<b>INITIATION – Prevention of maternal transmission</b> <b>Prerequisites</b> (tick boxes where appropriate)	
O Prevention of maternal foetal transmission	
O Treatment of the newborn for up to eight weeks	
INITIATION – Post-exposure prophylaxis following non-occupational exp	posure to HIV
Prerequisites (tick boxes where appropriate)	
O Treatment course to be initiated within 72 hours post exposure	
O Patient has had unprotected receptive anal intercourse	with a known HIV positive person
O Patient has shared intravenous injecting equipment with	a known HIV positive person
O Patient has had non-consensual intercourse and the clin required	nician considers that the risk assessment indicates prophylaxis is
INITIATION – Percutaneous exposure         Prerequisites (tick box where appropriate)         O       Patient has percutaneous exposure to blood known to be HIV positive	/e
INITIATION – Pre-exposure prophylaxis Re-assessment required after 24 months Prerequisites (tick boxes where appropriate)	
O Patient has tested HIV negative, does not have signs or symp	toms of acute HIV infection and has been assessed for HIV seroconversion
O The Practitioner considers the patient is at elevated risk of HIV	/ exposure and use of PrEP is clinically appropriate
Note: Refer to local health pathways or the Australasian Society for HIV, Viral	Hepatitis and Sexual Health Medicine clinical guidelines (https://ashm.org.au/HIV/F
CONTINUATION – Pre-exposure prophylaxis Re-assessment required after 24 months Prerequisites (tick boxes where appropriate)	
	toms of acute HIV infection and has been assessed for HIV seroconversion
The Practitioner considers the patient is at elevated risk of HIV	/ exposure and use of PrEP is clinically appropriate
Note: Refer to local health pathways or the Australasian Society for HIV, Viral	Hepatitis and Sexual Health Medicine clinical guidelines (https://ashm.org.au/HIV/F

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.

PRESCR	IBER	PATIENT:
Name: .		Name:
Ward:		NHI:
Oseltar	nivir	
INITIATI Prerequ	ON iisites (tick boxes where appropriate)	
	O Only for hospitalised patient with known or suspected influenza	a
or	a Health NZ Hospital approved infections control plan	

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.

PRES	SCR	IBER	PATIENT:	
Name	e:		Name:	
Ward:			NHI:	
Zanamivir - Powder for inhalation 5 mg				
INITIATION Prerequisites (tick boxes where appropriate)				
		O Only for hospitalised patient with known or suspected influenza	a	
	or	O For prophylaxis of influenza in hospitalised patients as part of a Health NZ Hospital approved infections control plan		

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:		
COVID-19 treatments			

### INITIATION

Prerequisites (tick box where appropriate)

Only if patient meets access criteria (as per https://pharmac.govt.nz/covid-oral-antivirals). Note the supply of treatment is via Pharmac's approved distribution process. Refer to the Pharmac website for more information about this and stock availability ()

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:
Remdesivir	

# **INITIATION – Treatment of mild to moderate COVID-19**

Prerequisites (tick box where appropriate)

 $\bigcirc$ Only if patient meets access criteria (as per https://pharmac.govt.nz/covid-oral-antivirals). Note the supply of treatment is via Pharmac's approved distribution process. Refer to the Pharmac website for more information about this and stock availability

#### **INITIATION – COVID-19 in hospitalised patients** Re-assessment required after 5 doses Prerequisites (tick boxes where appropriate) ( ) Patient is hospitalised with confirmed (or probable) symptomatic COVID-19 and Patient is considered to be at high risk of progression to severe disease and Patient's symptoms started within the last 7 days and Patient does not require, or is not expected to require, mechanical ventilation and Not to be used in conjunction with other funded COVID-19 antiviral treatments and Treatment not to exceed five days

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:
Interferon gamma	
INITIATION Prerequisites (tick box where appropriate)	
m O Patient has chronic granulomatous disease and requires interferon g	gamma

# RS1827 - Pegylated interferon alfa-2a

Chronic Hepatitis C - genotype 1 infection treatment more than 4 years prior - INITIATION Chronic hepatitis C - genotype 1 infection - CONTINUATION Chronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV or genotype 2 or 3 post liver tran - INITIATION	220 <mark>splant</mark>
Chronic hepatitis C - genotype 2 or 3 infection without co-infection with HIV - INITIATION	221
Myeloproliferative disorder or cutaneous T cell lymphoma - INITIATION Myeloproliferative disorder or cutaneous T cell lymphoma - CONTINUATION	222
Ocular surface squamous neoplasia - INITIATION	222
Post-allogenic bone marrow transplant - INITIATION Post-allogenic bone marrow transplant - CONTINUATION	

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:

# Pegylated interferon alfa-2a

INITIATION – Chronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV or genotype 2 or 3 post liver transplant Re-assessment required after 48 weeks
Prerequisites (tick boxes where appropriate)
O Patient has chronic hepatitis C, genotype 1, 4, 5 or 6 infection
O Patient has chronic hepatitis C and is co-infected with HIV
O Patient has chronic hepatitis C genotype 2 or 3 and has received a liver transplant
Note: Consider stopping treatment if there is absence of a virological response (defined as at least a 2-log reduction in viral load) following 12 weeks of treatment since this is predictive of treatment failure. Consider reducing treatment to 24 weeks if serum HCV RNA level at Week 4 is undetectable by sensitive PCR assay (less than 50IU/ml) AND Baseline serum HCV RNA is less than 400,000IU/ml.
CONTINUATION – Chronic hepatitis C - genotype 1 infection Re-assessment required after 48 weeks
Prerequisites (tick boxes where appropriate)
O Prescribed by, or recommended by a gastroenterologist, infectious disease specialist or general physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
O Patient has chronic hepatitis C, genotype 1 and
O Patient has had previous treatment with pegylated interferon and ribavirin and
O Patient has responder relapsed
O Patient was a partial responder
And O Patient is to be treated in combination with boceprevir
INITIATION – Chronic Hepatitis C - genotype 1 infection treatment more than 4 years prior Re-assessment required after 48 weeks
Prerequisites (tick boxes where appropriate)
O Prescribed by, or recommended by a gastroenterologist, infectious disease specialist or general physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
O Patient has chronic hepatitis C, genotype 1 and
Patient has had previous treatment with pegylated interferon and ribavirin and
O Patient has responder relapsed
or O Patient was a partial responder
O Patient received interferon treatment prior to 2004
And O Patient is to be treated in combination with boceprevir

# HOSPITAL MEDICINES LIST

July 2	n RS182 2025	27	RESTRICTIONS CHECKLIST	Page 22
		st to determine if a patient meets the rest community funding, see the Special Auth		For more details, refer to Section H of the Pharmaceutical
PRES	SCRIBER		PATIENT:	
Name	):		Name:	
Ward	:		NHI:	
Peg	lated ir	nterferon alfa-2a - continued		
		Chronic hepatitis C - genotype 2 or 3 at required after 6 months	infection without co-infection with HIV	
		(tick box where appropriate)		
	O Patie	nt has chronic hepatitis C, genotype 2 o	r 3 infection	
and		Patient has been endorsed by the Hea Patient has confirmed Hepatitis B infec Patient is Hepatitis B treatment-naive ALT > 2 times Upper Limit of Normal HBV DNA < 10 log10 IU/mI O HBeAg positive O Serum HBV DNA greater than or moderate fibrosis)	Ith NZ Hospital. tion (HBsAg positive for more than 6 month	general physician, or in accordance with a protocol or Is) Dosis (greater than or equal to Metavir Stage F2 or
	and	Compensated liver disease		
	and	No continuing alcohol abuse or intraver	nous drug use	
	O	Not co-infected with HCV, HIV or HDV		

O No history of hypersensitivity or contraindications to pegylated interferon

# INITIATION – myeloproliferative disorder or cutaneous T cell lymphoma Re-assessment required after 12 months

O Neither ALT nor AST > 10 times upper limit of normal

Prerequisites (tick boxes whe

Prerequisites	(tick boxes	where	appropriat	e)

and

and

or	O	Patient has a myeloproliferative disorder*
	and O and	Patient is intolerant of hydroxyurea
	0	Treatment with anagrelide and busulfan is not clinically appropriate
or	0	Patient has a myeloproliferative disorder
	and	Patient is pregnant, planning pregnancy or lactating

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:
Pegylated interferon alfa-2a - continued	
CONTINUATION – myeloproliferative disorder or cutaneous T cell lymp Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	homa
O No evidence of disease progression and O The treatment remains appropriate and patient is benefitting	from treatment
and O Patient has a cutaneous T cell lymphoma*	
or O Patient has a myeloproliferative disorder*	
or	atment with anagrelide and busulfan remains clinically inappropriate
O Patient is pregnant, planning pregnancy or	lactating
Note: Indications marked with * are unapproved indications	
Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by an ophthalmologist, or in accor Hospital. and O Patient has ocular surface squamous neoplasia*	dance with a protocol or guideline that has been endorsed by the Health NZ
CONTINUATION – ocular surface squamous neoplasia Re-assessment required after 12 months Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by an ophthalmologist, or in accor Hospital.	dance with a protocol or guideline that has been endorsed by the Health NZ
O The treatment remains appropriate and patient is benefitting from t Note: Indications marked with * are unapproved indications	reatment
INITIATION – post-allogenic bone marrow transplant         Re-assessment required after 3 months         Prerequisites (tick box where appropriate)         O       Patient has received an allogeneic bone marrow transplant* and has	as evidence of disease relapse
CONTINUATION – post-allogenic bone marrow transplant Re-assessment required after 3 months Prerequisites (tick box where appropriate)	
$O$ Patient is responding and ongoing treatment remains appropriate Note: Indications marked with $^{\ast}$ are unapproved indications	

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

# Musculoskeletal System

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:
Edrophonium chloride	
INITIATION Prerequisites (tick box where appropriate)	
${igodoldoldoldoldoldoldoldoldoldoldoldoldol$	

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:

### Denosumab

( and	С	The	patient has established osteoporosis
		0	History of one significant osteoporotic fracture demonstrated radiologically, with a documented T-Score less than or equal to -2.5, that incorporates BMD measured using dual-energy x-ray absorptiometry (DEXA)
	or	Ο	History of one significant osteoporotic fracture, demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of logistical, technical or pathophysiological reasons
	or	Ο	History of two significant osteoporotic fractures demonstrated radiologically
	or	Ο	Documented T-Score less than or equal to -3.0
	or	0	A 10-year risk of hip fracture greater than or equal to 3%, calculated using a published risk assessment algorithm that incorporates BMD measured using DEXA
nd	$\subseteq$		
	or	Ο	Bisphosphonates are contraindicated because the patient's creatinine clearance or eGFR is less than 35 mL/min
	•.	Ο	The patient has experienced at least two symptomatic new fractures or a BMD loss greater than 2% per year, after at least 12 months' continuous therapy with a funded antiresorptive agent
	or	0	Bisphosphonates result in intolerable side effects
	or	$\bigcirc$	Intravenous bisphosphonates cannot be administered due to logistical or technical reasons

#### INITIATION – Hypercalcaemia

Prerequisites (tick boxes where appropriate)



Patient has hypercalcaemia of malignancy

Patient has severe renal impairment

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:

### Raloxifene

		(tick boxes where appropriate)
or	0	History of one significant osteoporotic fracture demonstrated radiologically and documented bone mineral density (BMD) greater than or equal to 2.5 standard deviations below the mean normal value in young adults (i.e. T-Score less than or equal to -2.5) (see Notes)
	0	History of one significant osteoporotic fracture demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of major logistical, technical or pathophysiological reasons. It is unlikely that this provision would apply to many patients under 75 years of age
or	Ο	History of two significant osteoporotic fractures demonstrated radiologically
or	Ο	Documented T-Score greater than or equal to -3.0 (see Notes)
or	Ο	A 10-year risk of hip fracture greater than or equal to 3%, calculated using a published risk assessment algorithm (e.g. FRAX or Garvan) which incorporates BMD measurements (see Notes)
or	Ο	Patient has had a Special Authority approval for zoledronic acid (Underlying cause - Osteoporosis) or has had a Special Authority approval for alendronate (Underlying cause - Osteoporosis) prior to 1 February 2019

Note:

- a) BMD (including BMD used to derive T-Score) must be measured using dual-energy x-ray absorptiometry (DXA). Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable.
- b) Evidence suggests that patients aged 75 years and over who have a history of significant osteoporotic fracture demonstrated radiologically are very likely to have a T-Score less than or equal to -2.5 and, therefore, do not require BMD measurement for raloxifene funding.
- c) Osteoporotic fractures are the incident events for severe (established) osteoporosis, and can be defined using the WHO definitions of osteoporosis and fragility fracture. The WHO defines severe (established) osteoporosis as a T-score below -2.5 with one or more associated fragility fractures. Fragility fractures are fractures that occur as a result of mechanical forces that would not ordinarily cause fracture (minimal trauma). The WHO has quantified this as forces equivalent to a fall from a standing height or less.
- d) A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

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:	Name:
Ward:	NHI:

# Teriparatide

	IATION Issessmen	t required after 18 months
Prer	equisites	(tick boxes where appropriate)
	and	The patient has severe, established osteoporosis
	and	The patient has a documented T-score less than or equal to -3.0 (see Notes)
	and	The patient has had two or more fractures due to minimal trauma
	0	The patient has experienced at least one symptomatic new fracture after at least 12 months' continuous therapy with a funded antiresorptive agent at adequate doses (see Notes)

#### Note:

- a) The bone mineral density (BMD) measurement used to derive the T-score must be made using dual-energy x-ray absorptiometry (DXA). Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable
- b) Antiresorptive agents and their adequate doses for the purposes of this restriction are defined as: alendronate sodium tab 70 mg or tab 70 mg with colecalciferol 5,600 iu once weekly; raloxifene hydrochloride tab 60 mg once daily; zoledronic acid 5 mg per year. If an intolerance of a severity necessitating permanent treatment withdrawal develops during the use of one antiresorptive agent, an alternate antiresorptive agent must be trialled so that the patient achieves the minimum requirement of 12 months' continuous therapy.
- c) A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

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:	Name:
Ward:	NHI:
Rasburicase	

# INITIATION

Prerequisites (tick box where appropriate)

()Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

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:

### Febuxostat

(	С	Patie	ent has been diagnosed with gout
and			
		0	The patient has a serum urate level greater than 0.36 mmol/l despite treatment with allopurinol at doses of at least 600 mg/day and addition of probenecid at doses of up to 2 g per day or maximum tolerated dose
	or	Ο	The patient has experienced intolerable side effects from allopurinol such that treatment discontinuation is required and serum urate remains greater than 0.36 mmol/l despite use of probenecid at doses of up to 2 g per day or maximum tolerated dose
	or	0	The patient has renal impairment such that probenecid is contraindicated or likely to be ineffective and serum urate remains
	or	~	greater than 0.36 mmol/l despite optimal treatment with allopurinol (see Note)
		$\bigcirc$	The patient has previously had an initial Special Authority approval for benzbromarone for treatment of gout.

#### **INITIATION – Tumour lysis syndrome** Re-assessment required after 6 weeks

Prerequisites (tick boxes where appropriate)

O Prescribed by, or recommended by a haematologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

O Patient is scheduled to receive cancer therapy carrying an intermediate or high risk of tumour lysis syndrome and

O Patient has a documented history of allopurinol intolerance

#### **CONTINUATION – Tumour lysis syndrome**

Re-assessment required after 6 weeks **Prerequisites** (tick box where appropriate)

()

and

Prescribed by, or recommended by a haematologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

The treatment remains appropriate and patient is benefitting from treatment

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:

# Sugammadex

INITI Prere			(tick boxes where appropriate)
	or	0	Patient requires reversal of profound neuromuscular blockade following rapid sequence induction that has been undertaken using rocuronium (i.e. suxamethonium is contraindicated or undesirable)
	or	Ο	Severe neuromuscular degenerative disease where the use of neuromuscular blockade is required
		Ο	Patient has an unexpectedly difficult airway that cannot be intubated and requires a rapid reversal of anaesthesia and neuromuscular blockade
	or or	Ο	The duration of the patient's surgery is unexpectedly short
		Ο	Neostigmine or a neostigmine/anticholinergic combination is contraindicated (for example the patient has ischaemic heart disease, morbid obesity or COPD)
	or	0	Patient has a partial residual block after conventional reversal

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:
Etoricoxib	
INITIATION Prerequisites (tick box where appropriate)	
O For in-vivo investigation of allergy only	

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:
Capsaicin	

Prerequisites (tick box where appropriate)

O Patient has osteoarthritis that is not responsive to paracetamol and oral non-steroidal anti-inflammatories are contraindicated

Nervous System

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:
Riluzole	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a neurologist or respiratory speci by the Health NZ Hospital.	alist, or in accordance with a protocol or guideline that has been endorsed
<ul> <li>The patient has amyotrophic lateral sclerosis with disease dura and</li> <li>The patient has at least 60 percent of predicted forced vital cap and</li> <li>The patient has not undergone a tracheostomy and</li> <li>The patient has not experienced respiratory failure and</li> </ul>	

or O The patient is able to use upper limbs

The patient is ambulatory

 $\bigcirc$  The patient is able to swallow

#### CONTINUATION

Re-assessment required after 18 months

()

Prerequisites (tick boxes where appropriate)

O The patient has not undergone a tracheostomy			patient has not undergone a tracheostomy
and ( and	С	The p	patient has not experienced respiratory failure
and		0	The patient is ambulatory
	or	Ο	The patient is able to use upper limbs
	or	Ο	The patient is able to swallow

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:	Name:
Ward:	NHI:
Sucrose	
INITIATION Prerequisites (tick box where appropriate)	
O For use in neonatal patients only	

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.

PRES	CRIBER		PATIENT:		
Name	:		Name:		
Ward			NHI:		
Meth	oxyflur	ane			
	ATION equisites	(tick boxes where appropriate)			
	) and	Patient is undergoing a painful procedure with an expected du	ration of less than one hour		
	Ö	O Only to be used under supervision by a medical practitioner or nurse who is trained in the use of methoxyflurane			

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:
Paracetamol	

### INITIATION

Prerequisites (tick box where appropriate)

()Intravenous paracetamol is only to be used where other routes are unavailable or impractical, or where there is reduced absorption. The need for IV paracetamol must be re-assessed every 24 hours

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:
Capsaicin	
INITIATION Prerequisites (tick box where appropriate)	
O For post-herpetic neuralgia or diabetic peripheral neuropathy	

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:

# Vigabatrin

Re-a		men	equired after 15 months ck boxes where appropriate)		
		O Patient has infantile spasms			
Patient has epilepsy					
			O Seizures are not adequately controlled with optimal treatment with other antiepilepsy agents or		
			O Seizures are controlled adequately but the patient has experienced unacceptable side effects from optimal treatment with other antiepilepsy agents		
		or	O Patient has tuberous sclerosis complex		
	and				
			O Patient is, or will be, receiving regular automated visual field testing (ideally before starting therapy and on a 6-monthly basis thereafter)		
		or	O It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields		
$\subseteq$					
	NTINU requis		ck boxes where appropriate)		
	and	0	he patient has demonstrated a significant and sustained improvement in seizure rate or severity and or quality of life		
		or	Patient is receiving regular automated visual field testing (ideally every 6 months) on an ongoing basis for duration of treatment with vigabatrin		

O It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields

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:
Lacosamide	
INITIATION           Re-assessment required after 15 months           Prerequisites (tick boxes where appropriate)	
	erienced unacceptable side effects from, optimal treatment with all of the ny two of carbamazepine, lamotrigine, and phenytoin sodium (see Note)
Note: Those of childbearing potential are not required to trial phenytoin sodiul required to trial sodium valproate.	m, sodium valproate, or topiramate. Those who can father children are not

### CONTINUATION

Prerequisites (tick box where appropriate)

() Patient has demonstrated a significant and sustained improvement in seizure rate or severity and/or quality of life compared with that prior to starting lacosamide treatment

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:
Ctivinontal	

### Stiripentol

and

()

INITIATION         Re-assessment required after 6 months         Prereguisites (tick boxes where appropriate)
O Prescribed by, or recommended by a paediatric neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and
<ul> <li>Patient has confirmed diagnosis of Dravet syndrome</li> <li>Seizures have been inadequately controlled by appropriate courses of sodium valproate, clobazam and at least two of the following: topiramate, levetiracetam, ketogenic diet</li> </ul>
Note: Those of childbearing potential are not required to trial sodium valproate or topiramate. Those who can father children are not required to trial sodium valproate.
CONTINUATION Prerequisites (tick box where appropriate)

O Prescribed by, or recommended by a paediatric neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

Patient continues to benefit from treatment as measured by reduced seizure frequency from baseline

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:
Hyoscine hydrobromide - Patch 1.5 mg	

#### Prerequisites (tick boxes where appropriate) ()Control of intractable nausea, vomiting, or inability to swallow saliva in the treatment of malignancy or chronic disease where the patient cannot tolerate or does not adequately respond to oral anti-nausea agents or Control of clozapine-induced hypersalivation where trials of at least two other alternative treatments have proven ineffective or ()For treatment of post-operative nausea and vomiting where cyclizine, droperidol and a 5HT3 antagonist have proven ineffective, are not tolerated or are contraindicated

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:	
Aprepitant		

Prerequisites (tick box where appropriate)

O Patient is undergoing highly emetogenic chemotherapy and/or anthracycline-based chemotherapy for the treatment of malignancy

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:

# Paliperidone

sses	smer		uired after 12 months poxes where appropriate)
or	0		patient has had an initial Special Authority approval for risperidone depot injection or olanzapine depot injection or aripiprazole ot injection
	an	O d	The patient has schizophrenia or other psychotic disorder The patient has been unable to adhere to treatment using oral atypical antipsychotic agents
	an	d O	The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in the last 12 months

### CONTINUATION

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

The initiation of paliperidone depot injection has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of an atypical antipsychotic depot injection  $\bigcirc$ 

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:
Paliperidone palmitate	
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	liperidone once-monthly depot injection
CONTINUATION         Re-assessment required after 12 months         Prerequisites (tick box where appropriate)         O       The initiation of paliperidone depot injection has been associated wincorresponding period of time prior to the initiation of an atypical antiparticle	

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:
Olanzapine	

#### CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate)

 $\bigcirc$ The initiation of olanzapine depot injection has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of an atypical antipsychotic depot injection

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:

## Risperidone

Prerec				uired after 12 months boxes where appropriate)
C	or	0		patient has had an initial Special Authority approval for paliperidone depot injection or olanzapine depot injection or aripiprazole t injection
		an	O	The patient has schizophrenia or other psychotic disorder
		an	Ο	The patient has not been able to adhere to treatment using oral atypical antipsychotic agents
			0	The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in the last 12 months

### CONTINUATION

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

The initiation of risperidone depot injection has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of an atypical antipsychotic depot injection  $\bigcirc$ 

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:

## Aripiprazole

	or	O The patient has had an initial Special Authority approval for risperidone depot injection or paliperidone depot injection or olanzapine depot injection
		O The patient has schizophrenia or other psychotic disorder
		and O The patient has received treatment with oral atypical antipsychotic agents but has been unable to adhere
		The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in last 12 months
or	0	Patient has been unable to access olanzapine depot injection due to supply issues with olanzapine depot injection, or otherwise would have been initiated on olanzapine depot injection but has been unable to due to supply issues with olanzapine depot injection. (see Note below for the olanzapine Special Authority criteria for new olanzapine depot injection patients prior to 1 April 2024)

- All of the following:
  - The patient has schizophrenia; and
  - The patient has tried but has not been able to adhere with treatment using oral atypical antipsychotic agents; and
  - The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in the last 12 months.

and

# 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:
Diazepam	
INITIATION           Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a relevant specialist, or in accord Hospital.	dance with a protocol or guideline that has been endorsed by the Health NZ

Only for use in children where diazepam tablets are not appropriate

SCRIBER		PATIENT:
e:		Name:
I:		NHI:
tiple Scler	rosis	
teriflunomic assessment r requisites (ti O Prescri NZ Hos	de required after 12 months ick boxes where appropriate) bed by, or recommended by any relevant practitioner, o	latiramer acetate, interferon beta-1-alpha, interferon beta-1-beta, natalizum
and	<ul> <li>Diagnosis of multiple sclerosis (MS) meets the M neurologist</li> <li>Patient has an EDSS score between 0 - 6.0</li> </ul>	cDonald 2017 diagnostic criteria for MS and has been confirmed by a
and ( and	O Patient has had at least one significant attack of I	MS in the previous 12 months or two significant attacks in the past 24 months
	and Each significant attack is associated with cl experienced symptoms(s)/sign(s) and Each significant attack has lasted at least cl attack (where relevant) and	by the applying neurologist or general physician (the patient may not g the attack, but the neurologist/physician must be satisfied that the clinical haracteristic new symptom(s)/sign(s) or substantially worsening of previously one week and has started at least one month after the onset of a previous d from the effects of general fatigue; and is not associated with a fever (T>
	System scores by at least 1 point	ugh to change either the EDSS or at least one of the Kurtze Functional paroxysmal symptom of multiple sclerosis (tonic seizures/spasms, ptom)
and ( and	Evidence of new inflammatory activity on an MRI	scan within the past 24 months MRI scanning (in criterion 5 immediately above) is a gadolinium enhancing
	or O A sign of that new inflammatory activity of a sign of that new inflammatory activity is a or	
	O A sign of that new inflammatory is a T2 les	ion with associated local swelling
	O A sign of that new inflammatory activity is a recent attack that occurred within the last 2	a prominent T2 lesion that clearly is responsible for the clinical features of a years
	$\overline{\mathbf{O}}$	new T2 lesions compared with a previous MRI scan

()

and

#### 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:

### Multiple Sclerosis - continued

CONTINUATION - Multiple Sclerosis - dimethyl fumarate, fingolimod, glatiramer acetate, interferon beta-1-alpha, interferon beta-1-beta, natalizumab and teriflunomide

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

Patient has had an EDSS score of 0 to 6.0 (inclusive) with or without the use unilateral or bilateral aids at any time in the last six months (ie the patient has walked 100 metres or more with or without aids in the last six months) Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.

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.

SCRIBER	PATIENT:
ə:	Name:
:	NHI:
iple Sclerosis	
assessment required a requisites (tick boxes	
and Patie	nosis of multiple sclerosis (MS) meets the McDonald 2017 diagnostic criteria for MS and has been confirmed by a ologist ent has an EDSS score between 0 – 6.0 ent has had at least one significant attack of MS in the previous 12 months or two significant attacks in the past 24 months
and and and and and and and or	Each significant attack must be confirmed by the applying neurologist or general physician (the patient may not necessarily have been seen by them during the attack, but the neurologist/physician must be satisfied that the clinical features were characteristic) Each significant attack is associated with characteristic new symptom(s)/sign(s) or substantially worsening of previously experienced symptoms(s)/sign(s) Each significant attack has lasted at least one week and has started at least one month after the onset of a previous attack (where relevant) Each significant attack can be distinguished from the effects of general fatigue; and is not associated with a fever (T> 37.5°C) O Each significant attack is severe enough to change either the EDSS or at least one of the Kurtze Functional System scores by at least 1 point
and	O Each significant attack is a recurrent paroxysmal symptom of multiple sclerosis (tonic seizures/spasms, trigeminal neuralgia, Lhermitte's symptom) ence of new inflammatory activity on an MRI scan within the past 24 months A sign of that new inflammatory activity on MRI scanning (in criterion 5 immediately above) is a gadolinium enhancing lesion
or or or or	<ul> <li>A sign of that new inflammatory activity is a lesion showing diffusion restriction</li> <li>A sign of that new inflammatory is a T2 lesion with associated local swelling</li> <li>A sign of that new inflammatory activity is a prominent T2 lesion that clearly is responsible for the clinical features of a recent attack that occurred within the last 2 years</li> <li>A sign of that new inflammatory activity is new T2 lesions compared with a previous MRI scan</li> </ul>

Use this checklist to determine if a patient meets the restrictions for funding in t Schedule. For community funding, see the Special Authority Criteria.	he <b>hospital setting</b> . For more details, refer to Section H of the Pharmaceutical
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Multiple Sclerosis - continued	
CONTINUATION – Multiple Sclerosis - ocrelizumab	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by any relevant practitioner, or in a NZ Hospital.	ccordance with a protocol or guideline that has been endorsed by the Health
INITIATION – Primary Progressive Multiple Sclerosis         Re-assessment required after 12 months         Prerequisites (tick boxes where appropriate)         O       Prescribed by, or recommended by any relevant practitioner, or in an NZ Hospital.	ccordance with a protocol or guideline that has been endorsed by the Health
CONTINUATION – Primary Progressive Multiple Sclerosis Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by any relevant practitioner, or in a NZ Hospital.	ccordance with a protocol or guideline that has been endorsed by the Health
$\sim$	ime in the last six months (ie patient has walked 20 metres with bilateral

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:	Name:			
Ward:	NHI:			
Melatonin				
INITIATION – insomnia secondary to neurodevelopmental disorder Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)				
O Prescribed by, or recommended by a psychiatrist, paediatrician, neu guideline that has been endorsed by the Health NZ Hospital.	urologist or respiratory specialist, or in accordance with a protocol or			
	somnia secondary to a neurodevelopmental disorder (including, but not activity disorder)			
O Behavioural and environmental approaches have been tried or are inappropriate				
O Funded modified-release melatonin is to be given at doses no and	O Funded modified-release melatonin is to be given at doses no greater than 10 mg per day			
O Patient is aged 18 years or under				
CONTINUATION – insomnia secondary to neurodevelopmental disorder Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a psychiatrist, paediatrician, neu guideline that has been endorsed by the Health NZ Hospital.	urologist or respiratory specialist, or in accordance with a protocol or			
O Patient is aged 18 years or under				
	unded modified-release melatonin (clinician determined) discontinuation within the past 12 months and has had a recurrence of			
and Funded modified-release melatonin is to be given at doses no	o greater than 10 mg per day			
INITIATION – insomnia where benzodiazepines and zopicione are contra Prerequisites (tick boxes where appropriate)	aindicated			
O Patient has insomnia and benzodiazepines and zopiclone are and O For in-hospital use only	e contraindicated			

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:	Name:		
Ward:	NHI:		

### Nusinersen

	ATION	
Re-a	ssessmer	nt required after 12 months
Prere	equisites	(tick boxes where appropriate)
	and and	Patient has genetic documentation of homozygous SMN1 gene deletion, homozygous SMN1 point mutation, or compound heterozygous mutation Patient is 18 years of age or under
	or	O Patient has experienced the defined signs and symptoms of SMA type I, II or IIIa prior to three years of age
		O Patient is pre-symptomatic
		O Patient has three or less copies of SMN2
Re-a		DN at required after 12 months (tick boxes where appropriate)
	) and	There has been demonstrated maintenance of motor milestone function since treatment initiation
	0	Patient does not require invasive permanent ventilation (at least 16 hours per day), in the absence of a potentially reversible cause while being treated with nusinersen
	and	Nusinersen not to be administered in combination other SMA disease modifying treatments or gene therapy

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:		

### Risdiplam

	sessmer	nt required after 12 months (tick boxes where appropriate)
	O	Patient has genetic documentation of homozygous SMN1 gene deletion, homozygous SMN1 point mutation, or compound heterozygous mutation
		Patient is 18 years of age or under
	or	O Patient has experienced the defined signs and symptoms of SMA type I, II or IIIa prior to three years of age
		O Patient is pre-symptomatic and O Patient has three endow endow endow endow
		Patient has three or less copies of SMN2
Re-ass		DN Int required after 12 months (tick boxes where appropriate)
		There has been demonstrated maintenance of motor milestone function since treatment initiation
	0	Patient does not require invasive permanent ventilation (at least 16 hours per day), in the absence of a potentially reversible cause while being treated with risdiplam
Ĩ		Risdiplam not to be administered in combination other SMA disease modifying treatments or gene therapy

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:		

### Modafinil

INITIATION – Narcolepsy Prerequisites (tick boxes where appropriate)							
		Prescribed by, or recommended by a neurologist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.					
	O The patient has a diagnosis of narcolepsy and has excessive daytime sleepiness associated with narcolepsy occurring almost daily for three months or more and						
		or	<ul> <li>O The patient has a multiple sleep latency test with a mean sleep latency of less than or equal to 10 minutes and 2 or more sleep onset rapid eye movement periods</li> <li>O The patient has at least one of: cataplexy, sleep paralysis or hypnagogic hallucinations</li> </ul>				
	and	or	<ul> <li>An effective dose of a listed formulation of methylphenidate or dexamphetamine has been trialled and discontinued because of intolerable side effects</li> <li>Methylphenidate and dexamphetamine are contraindicated</li> </ul>				
or	(and	C C	Patient meets the Hospital Restriction criteria for methylphenidate hydrochloride for narcolepsy Patient is unable to access methylphenidate hydrochloride presentations due to an out of stock (see note)				

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:		

## Lisdexamfetamine dimesilate

#### INITIATION

Prerequisites (tick boxes where appropriate)

()Prescribed by, or recommended by a paediatrician or psychiatrist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and

	( and	С	ADHD	0 (Attention Deficit and Hyperactivity Disorder)
Diagnosed according to DSM-V or ICD 11 criteria				osed according to DSM-V or ICD 11 criteria
				Patient is taking a currently subsidised formulation of atomoxetine or methylphenidate hydrochloride (extended-release and has not received sufficient benefit or has experienced intolerable side effects
			Patient is taking a currently subsidised formulation of dexamfetamine sulfate (immediate-release) which has not been effective due to significant administration and/or treatment adherence difficulties	
		or O Patient is taking a currently subsidised formulation of methylphenidate hydrochloride (immediate-rel		There is significant concern regarding the risk of diversion or abuse of immediate release dexamfetamine sulfate
				Patient is taking a currently subsidised formulation of methylphenidate hydrochloride (immediate-release or sustained release) which has not been effective due to significant administration and/or treatment adherence difficulties
	or		0	There is significant concern regarding the risk of diversion or abuse of immediate release methylphenidate hydrochloric
			and	O Patient would have been prescribed a subsidised formulation of methylphenidate hydrochloride (extended-release) but has been unable to access due to supply issues with methylphenidate hydrochloride (extended-release)
			and	O Other alternative stimulant presentations (methylphenidate or dexamfetamine) are not appropriate

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:	Name:				
Ward:	NHI:				
Methylphenidate hydrochloride					
<b>INITIATION – ADHD (immediate-release and sustained-release formulat</b> <b>Prerequisites</b> (tick box where appropriate)	ions)				
Health NZ Hospital.	O Prescribed by, or recommended by a paediatrician or psychiatrist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
Patient has ADHD (Attention Deficit and Hyperactivity Disorder), di	agnosed according to DSM-IV or ICD 10 criteria				
INITIATION – Narcolepsy (immediate-release and sustained-release for Prerequisites (tick box where appropriate)	nulations)				
by the Health NZ Hospital.	cialist, or in accordance with a protocol or guideline that has been endorsed				
O Patient suffers from narcolepsy					
<b>INITIATION – Extended-release and modified-release formulations</b> <b>Prerequisites</b> (tick boxes where appropriate)					
O Prescribed by, or recommended by a paediatrician or psychiatrist, o Health NZ Hospital.	or in accordance with a protocol or guideline that has been endorsed by the				
Patient has ADHD (Attention Deficit and Hyperactivity Disord	er), diagnosed according to DSM-IV or ICD 10 criteria				
O Patient is taking a currently listed formulation of methyl has not been effective due to significant administration	phenidate hydrochloride (immediate-release or sustained-release) which and/or compliance difficulties				
	ion or abuse of immediate-release methylphenidate hydrochloride				
INITIATION – Narcolepsy* (extended-release only) Prerequisites (tick box where appropriate)					

O Prescribed by, or recommended by a neurologist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

O Patient suffers from narcolepsy

and

Note: \*narcolepsy is not a registered indication for Concerta or Ritalin LA.

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.

PRESCR	IBER	PATIENT:		
Name: .		Name:		
Ward:		NHI:		
Dexam	phetamine sulphate			
	ON – ADHD isites (tick box where appropriate)			
O Prescribed by, or recommended by a paediatrician or psychiatrist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
and	Patient has ADHD (Attention Deficit and Hyperactivity Disorder), dia	gnosed according to DSM-IV or ICD 10 criteria		
	INITIATION – Narcolepsy			
Prerequ	isites (tick box where appropriate)			
O Prescribed by, or recommended by a neurologist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
and	O Patient suffers from narcolepsy			

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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:
Rivastigmine	
INITIATION         Re-assessment required after 6 months         Prerequisites (tick boxes where appropriate)         O         The patient has been diagnosed with dementia         and         O         The patient has experienced intolerable nausea and/or vomiting	ng from donepezil tablets
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O The treatment remains appropriate and O The patient has demonstrated a significant and sustained beneficial	efit from treatment

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:
Naltrexone hydrochloride	
INITIATION – Alcohol dependence Prerequisites (tick boxes where appropriate)	
O Patient is currently enrolled, or is planned to be enrolled, in a and O Naltrexone is to be prescribed by, or on the recommendation of	recognised comprehensive treatment programme for alcohol dependence of, a physician working in an Alcohol and Drug Service
INITIATION – Constipation Prerequisites (tick box where appropriate) O For the treatment of opioid-induced constipation	

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.

PRES	CRI	BER		PATIENT:
Name	:			Name:
Ward:				NHI:
Nico	tine	e		
INITI. Prere		sites	(tick boxes where appropriate) For perioperative use in patients who have a 'nil by mouth' inst	ruction
	or	0	For use within mental health inpatient units	
	or	0	Patient would be admitted to a mental health inpatient unit, but	t is unable to due to COVID-19 self-isolation requirement
		0	For acute use in agitated patients who are unable to leave the	hospital facilities

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:	

### Varenicline

ITIATION rerequisites (tick boxes where appropriate)			
	0	Short-term therapy as an aid to achieving abstinence in a patient who has indicated that they are ready to cease smoking	
and	0	The patient is part of, or is about to enrol in, a comprehensive support and counselling smoking cessation programme, which includes prescriber or nurse monitoring	
	O The patient has tried but failed to quit smoking after at least two separate trials of nicotine replacement therapy, at least one of which included the patient receiving comprehensive advice on the optimal use of nicotine replacement therapy		
	or	O The patient has tried but failed to quit smoking using bupropion or nortriptyline	
and	Ο	The patient has not had a Special Authority for varenicline approved in the last 6 months	
		Varenicline is not to be used in combination with other pharmacological smoking cessation treatments and the patient has agreed to this	
	Ο	The patient is not pregnant	
and	Ο	The patient will not be prescribed more than 12 weeks' funded varenicline in a 12 month period	

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:
Buprenorphine with naloxone	
INITIATION – Detoxification         Prerequisites (tick boxes where appropriate)         O       Patient is opioid dependent         and       O         Patient is currently engaged with an opioid treatment service a         and       O         Prescriber works in an opioid treatment service approved by the	
INITIATION – Maintenance treatment           Prerequisites (tick boxes where appropriate)	
O Patient is opioid dependent	
Patient will not be receiving methadone and	
O Patient is currently enrolled in an opioid substitution treatment	program in a service approved by the Ministry of Health
O Prescriber works in an opioid treatment service approved by the	he Ministry of Health

# **Oncology Agents and Immunosuppressants**

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:	
Bendamustine I	hydrochloride	
INITIATION – CLL* Prerequisites (tick and Pati and Ben	* boxes where appropriate) e patient has chronic lymphocytic leukaemia requiring treatment ient has ECOG performance status 0-2 ndamustine is to be administered at a maximum dose of 100 mg/m <sup>2</sup> on days 1 and 2 every 4 weeks for a maximum of 6 cycles	
Note: Indication ma (SLL).	arked with a * includes indications that are unapproved. 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma	
Re-assessment req Prerequisites (tick	Ilent, Low-grade lymphomas quired after 9 months a boxes where appropriate) e patient has indolent low grade NHL requiring treatment ient has ECOG performance status of 0-2	
or a or	<ul> <li>Patient is treatment naive</li> <li>Bendamustine is to be administered for a maximum of 6 cycles (in combination with rituximab when CD20+)</li> <li>Patient is refractory to or has relapsed within 12 months of a rituximab containing combined chemo-immunotherapy regimen</li> <li>Bendamustine is to be administered in combination with obinutuzumab for a maximum of 6 cycles</li> </ul>	
	Bendamustine is to be administered for a maximum of 6 cycles in relapsed patients (in combination with rituximab when CD20+) Patient has had a rituximab treatment-free interval of 12 months or more Bendamustine is to be administered as monotherapy for a maximum of 6 cycles in rituximab refractory patients	

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:
Bendamustine hydrochloride - continued	
CONTINUATION – Indolent, Low-grade lymphomas Re-assessment required after 9 months	
Prerequisites (tick boxes where appropriate)	
O Patient is refractory to or has relayed within 12 months	of rituximab in combination with bendamustine

	and O Bendamustine is to be administered in combination with obinutuzumab for a maximum of 6 cycles		
	•	Patients have not received a bendamustine regimen within the last 12 months	
		Bendamustine is to be administered for a maximum of 6 cycles in relapsed rituximab when CD20+)	d patients (in combination with
		O Patient has had a rituximab treatment-free interval of 12 months or more	
		or $O$ Bendamustine is to be administered as a monotherapy for a maximum of 6 cycles	s in rituximab refractory patients
Note:	'ind	dolent, low-grade lymphomas' includes follicular, mantle cell, marginal zone and lymphoplasmacytic/	Waldenström's macroglobulinaemia.
Re-as	ssess	DN – Hodgkin's lymphoma* esement required after 6 months isites (tick boxes where appropriate)	
	and	O Patient has Hodgkin's lymphoma requiring treatment	
		O Patient has a ECOG performance status of 0-2	

Patient has a ECOG performance status of 0-2
 and
 Patient has received one prior line of chemotherapy
 and
 Patient's disease relapsed or was refractory following prior chemotherapy
 and

O Bendamustine is to be administered in combination with gemcitabine and vinorelbine (BeGeV) at a maximum dose of no greater than 90 mg/m2 twice per cycle, for a maximum of four cycles

Note: Indications marked with \* are unapproved indications.

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:	

## Azacitidine

INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)		
<ul> <li>O The individual has intermediate or high risk MDS based on an internationally recognised scoring system</li> <li>O The individual has chronic myelomonocytic leukaemia (based on an intermediate or high risk score from an internationally recognised scoring system or 10%-29% marrow blasts without myeloproliferative disorder)</li> <li>O The individual has acute myeloid leukaemia according to World Health Organisation (WHO) Classification</li> </ul>		
and O The individual has an estimated life expectancy of at least 3 months		
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate)		
O No evidence of disease progression		

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:
Mercaptopurine	
INITIATION Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a paediatric haematologist or pa been endorsed by the Health NZ Hospital. and O The patient requires a total dose of less than one full 50 mg tablet pa	ediatric oncologist, or in accordance with a protocol or guideline that has er day
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a paediatric haematologist or pa been endorsed by the Health NZ Hospital. and O The patient requires a total dose of less than one full 50 mg tablet p	ediatric oncologist, or in accordance with a protocol or guideline that has er day

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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:		

#### Venetoclax

		relapsed/refractory chronic lymphocytic leukaemia t required after 7 months
Prer	equisites	(tick boxes where appropriate)
	Ο	Individual has chronic lymphocytic leukaemia requiring treatment
	and	Individual has received at least one prior therapy for chronic lymphocytic leukaemia
	and	Individual has not previously received funded venetoclax
	and	The individual's disease has relapsed
	and	Venetoclax to be used in combination with six 28-day cycles of rituximab commencing after the 5-week dose titration schedule with venetoclax
	and	Individual has an ECOG performance status of 0-2

#### CONTINUATION - relapsed/refractory chronic lymphocytic leukaemia

### Re-assessment required after 6 months

()

and

Prerequisites (tick boxes where appropriate)

Treatment remains clinically appropriate and the individual is benefitting from and tolerating treatment

Venetoclax is to be discontinued after a maximum of 24 months of treatment following the titration schedule unless earlier discontinuation is required due to disease progression or unacceptable toxicity

Re-as	sessmer	previously untreated chronic lymphocytic leukaemia with 17p deletion or TP53 mutation* nt required after 6 months (tick boxes where appropriate)
	Ο	Individual has previously untreated chronic lymphocytic leukaemia
	and O and	There is documentation confirming that the individual has 17p deletion by FISH testing or TP53 mutation by sequencing
		Individual has an ECOG performance status of 0-2

#### **CONTINUATION – previously untreated chronic lymphocytic leukaemia with 17p deletion or TP53 mutation\*** Re-assessment required after 6 months

**Prerequisites** (tick box where appropriate)

O No evidence of disease progression

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL)\* and B-cell prolymphocytic leukaemia (B-PLL)\*. Indications marked with \* are unapproved indications

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.

PRES	CRIB	ER			PATIENT:
Name	:				Name:
Ward:					NHI:
Vene	tocl	ax -	conti	nued	
Re-a	ssess	ment	t requi	<b>usly untreated acute myeloid leukaemia</b> ired after 6 months oxes where appropriate)	
	( or	С	The i	ndividual is currently on treatment with venetoclax and me	et all remaining special authority criteria prior to commencing treatment
		and	0	Individual has previously untreated acute myeloid leukae Classification	emia (see note a), according to World Health Organization (WHO)
			Ο	Venetoclax not to be used in combination with standard	intensive remission induction chemotherapy
	O Venetoclax to be used in combination with azacitidine or low dose cytarabine				

#### **CONTINUATION – previously untreated acute myeloid leukaemia** Re-assessment required after 6 months

**Prerequisites** (tick box where appropriate)

O No evidence of disease progression Note:

a) 'Acute myeloid leukaemia' includes myeloid sarcoma\*

b) Indications marked with \* are Unapproved indications

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.

PRESC	RIBER	PATIENT:
Name:		Name:
Ward:		NHI:

### Olaparib

	essr	nent	t requir	red a	iter 12 months where appropriate)
and		resc ospi		oy, or	recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
a	ind	~			a high-grade serous* epithelial ovarian, fallopian tube, or primary peritoneal cancer cumentation confirming pathogenic germline BRCA1 or BRCA2 gene mutation
a	Ind		and	Ο	Patient has newly diagnosed, advanced disease Patient has received one line** of previous treatment with platinum-based chemotherapy Patient's disease must have experienced a partial or complete response to the first-line platinum-based regimen
		or	and		Patient has received at least two lines** of previous treatment with platinum-based chemotherapy Patient has platinum sensitive disease defined as disease progression occurring at least 6 months after the last dose of the penultimate line** of platinum-based chemotherapy Patient's disease must have experienced a partial or complete response to treatment with the immediately preceding platinum-based regimen Patient has not previously received funded olaparib treatment
а	ind ind ind		Treatn	nenti	will be commenced within 12 weeks of the patient's last dose of the immediately preceding platinum-based regimen to be administered as maintenance treatment not to be administered in combination with other chemotherapy

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.

PRES	CRIB	ER	PATIENT:
Name:			Name:
Ward:			NHI:
Olapa	arib	- <i>co</i>	ntinued
Re-as	ssessi quisi	men ites	N – Ovarian cancer required after 12 months (tick boxes where appropriate) ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal.
and	( and	С	Treatment remains clinically appropriate and patient is benefitting from treatment
		or	<ul> <li>No evidence of progressive disease</li> <li>Evidence of residual (not progressive) disease and the patient would continue to benefit from treatment in the clinician's opinion</li> </ul>
	and ( and ( and	С С	Treatment to be administered as maintenance treatment Treatment not to be administered in combination with other chemotherapy
		or	<ul> <li>Patient has received one line** of previous treatment with platinum-based chemotherapy</li> <li>Documentation confirming that the patient has been informed and acknowledges that the funded treatment period of olaparib will not be continued beyond 2 years if the patient experiences a complete response to treatment and there is no radiological evidence of disease at 2 years</li> </ul>
			O Patient has received at least two lines** of previous treatment with platinum-based chemotherapy

Note: \*Note "high-grade serous" includes tumours with high-grade serous features or a high-grade serous component \*\*A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments.

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:
Ibrutinib	
INITIATION – chronic lymphocytic leukaemia (CLL)         Re-assessment required after 6 months         Prerequisites (tick boxes where appropriate)         Individual has chronic lymphocytic leukaemia (CLL) requiring and         Individual has not previously received funded ibrutinib         and         Individual has not previously received funded ibrutinib         and         Ibrutinib is to be used as monotherapy	therapy
O There is documentation confirming that the individ	lual has 17p deletion or TP53 mutation

Individual has experienced intolerable side effects with venetoclax in combination with rituximab regimen

Individual has experienced intolerable side effects with venetoclax monotherapy

Individual has received at least one prior immunochemotherapy for CLL

CONTINUATION – chronic lymphocytic leukaemia	(CLL)	
Re-assessment required after 12 months		

Individual's CLL has relapsed

Prerequisites (tick box where appropriate)

and

and

and

()

or

or

()

No evidence of clinical disease progression

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL) and B-cell prolymphocytic leukaemia (B-PLL)\*. Indications marked with \* are Unapproved indications.

O Individual's CLL is refractory to or has relapsed following a venetoclax regimen

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:		

### Niraparib

	essme	nt required after 6 months (tick boxes where appropriate)
a a a a		Patient has advanced high-grade serous* epithelial ovarian, fallopian tube, or primary peritoneal cancer Patient has received at least one line** of treatment with platinum-based chemotherapy Patient has experienced a partial or complete response to the preceding treatment with platinum-based chemotherapy Patient has not previously received funded treatment with a PARP inhibitor O Treatment will be commenced within 12 weeks of the patient's last dose of the preceding platinum-based regimen O Patient commenced treatment with niraparib prior to 1 May 2024 Treatment to be administered as maintenance treatment Treatment not to be administered in combination with other chemotherapy
Prereq	essme	nt required after 6 months (tick boxes where appropriate) No evidence of progressive disease Treatment to be administered as maintenance treatment Treatment not to be administered in combination with other chemotherapy O Treatment with niraparib to cease after a total duration of 36 months from commencement

Note: \* "high-grade serous" includes tumours with high-grade serous features or a high-grade serous component. \*\*A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments

Use this checklist to determine if a patient meets the restrictions for funding i Schedule. For community funding, see the Special Authority Criteria.	in the <b>hospital setting</b> . For more details, refer to Section H of the Pharmaceutical
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Lenalidomide	
INITIATION – Plasma cell dyscrasia Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by any relevant practitioner, or in NZ Hospital.	n accordance with a protocol or guideline that has been endorsed by the Health
O Patient has plasma cell dyscrasia, not including Waldenstro and O Patient is not refractory to prior lenalidomide use	öm macroglobulinaemia, requiring treatment
INITIATION – Myelodysplastic syndrome         Re-assessment required after 6 months         Prerequisites (tick boxes where appropriate)         O       Prescribed by, or recommended by any relevant practitioner, or in NZ Hospital.	n accordance with a protocol or guideline that has been endorsed by the Health
and Patient has low or intermediate-1 risk myelodysplastic sync a deletion 5q cytogenetic abnormality and Patient has transfusion-dependent anaemia	drome (based on IPSS or an IPSS-R score of less than 3.5) associated with
	n accordance with a protocol or guideline that has been endorsed by the Health
ANZ Hospital.	

and

and

()

and

#### 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:		
Pomalidomide			
INITIATION – Relapsed/refractory plasma cell dyscrasia Re-assessment required after 6 months			

**Prerequisites** (tick boxes where appropriate)

Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

O Patient has relapsed or refractory plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment

Patient has not received prior funded pomalidomide

#### CONTINUATION - Relapsed/refractory plasma cell dyscrasia

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

Patient has no evidence of disease progression

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Temozolomide	
INITIATION – gliomas Re-assessment required after 12 months Prerequisites (tick box where appropriate)	
O Patient has a glioma	
CONTINUATION – gliomas Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Treatment remains appropriate and patient is benefitting fro	om treatment
INITIATION – Neuroendocrine tumours Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)	
<ul> <li>Patient has been diagnosed with metastatic or unresand</li> <li>Temozolomide is to be given in combination with capand</li> <li>Temozolomide is to be used in 28 day treatment cycl per day</li> <li>Temozolomide to be discontinued at disease progresand</li> </ul>	ecitabine es for a maximum of 5 days treatment per cycle at a maximum dose of 200 mg/m <sup>2</sup>
CONTINUATION – Neuroendocrine tumours Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O No evidence of disease progression and O The treatment remains appropriate and the patient is	benefitting from treatment
INITIATION – ewing's sarcoma Re-assessment required after 9 months Prerequisites (tick box where appropriate)	
O Patient has relapse or refractory Ewing's sarcoma	
CONTINUATION – ewing's sarcoma Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O No evidence of disease progression and	benefitting from treatment

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:	Name:
Ward:	NHI:
Thalidomide	
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	

 $\bigcirc$ The patient has plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment

The patient has erythema nodosum leprosum

#### CONTINUATION

or

Prerequisites (tick box where appropriate)

O Patient has obtained a response from treatment during the initial approval period Note: Prescription must be written by a registered prescriber in the thalidomide risk management programme operated by the supplier Maximum dose of 400 mg daily as monotherapy or in a combination therapy regimen

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:	
Bortezomib		
NITIATION – plasma cell dyscrasia		

Prerequisites (tick box where appropriate)

m O The patient has plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment

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:
Pegaspargase	
INITIATION – Newly diagnosed ALL         Re-assessment required after 12 months         Prerequisites (tick boxes where appropriate)         O         The patient has newly diagnosed acute lymphoblastic leukaen	nia
and O Pegaspargase to be used with a contemporary intensive multi	
INITIATION – Relapsed ALL Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
O The patient has relapsed acute lymphoblastic leukaemia and O Pegaspargase to be used with a contemporary intensive multi	-agent chemotherapy treatment protocol
INITIATION – Lymphoma Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Patient has lymphoma requiring L-asparaginase containing protocol	(e.g. SMILE)
O Patient has lymphoma requiring L-asparaginase containing protocol	(e.g. SMILE)

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.

PRESC	RIBER	PATIENT:
Name:		Name:
Ward:		NHI:

### Nilotinib

INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)		
( and		Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	and	O Patient has a diagnosis of chronic myeloid leukaemia (CML) in blast crisis, high risk chronic phase, or in chronic phase
		O Patient has documented CML treatment failure* with a tyrosine kinase inhibitor (TKI)
		O Patient has experienced treatment limiting toxicity with a tyrosine kinase inhibitor (TKI) precluding further treatment
	and	O Maximum nilotinib dose of 800 mg/day
	and	O Subsidised for use as monotherapy only
Note	: *trea	atment failure as defined by Leukaemia Net Guidelines.
Re-a	ssess	ATION ment required after 6 months ites (tick boxes where appropriate)
( and		Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	and	O Lack of treatment failure while on nilotinib as defined by Leukaemia Net Guidelines
	and	O Nilotinib treatment remains appropriate and the patient is benefiting from treatment
	and	O Maximum nilotinib dose of 800 mg/day
	and	O Subsidised for use as monotherapy only

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:

### Ruxolitinib

INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)				
( and		Preso Hosp	cribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.	
O The patient has primary myelofibrosis or post-polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis and			The patient has primary myelofibrosis or post-polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis	
	A classification of risk of intermediate-2 or high-risk myelofibrosis according to either the International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or the Age-Adjusted DIPSS			
			A classification of risk of intermediate-1 myelofibrosis according to either the International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or the Age-Adjusted DIPSS and	
			O Patient has severe disease-related symptoms that are resistant, refractory or intolerant to available therapy	
	and	0	A maximum dose of 20 mg twice daily is to be given	
CONTINUATION				

Re-assessment required after 12 months **Prerequisites** (tick boxes where appropriate)

and

The treatment remains appropriate and the patient is benefiting from treatment

A maximum dose of 20 mg twice daily is to be given

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:
Alectinib	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	-small cell lung cancer < tyrosine kinase gene rearrangement using an appropriate ALK test
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O No evidence of progressive disease according to RECIST crite and O The patient is benefitting from and tolerating treatment	eria

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:

### Palbociclib (Ibrance)

	( and	С	Patient has unresectable locally advanced or metastatic breast cancer
		С	There is documentation confirming disease is hormone-receptor positive and HER2-negative
	and ( and	С	Patient has an ECOG performance score of 0-2
		or	O Disease has relapsed or progressed during prior endocrine therapy
			O Patient is amenorrhoeic, either naturally or induced, with endocrine levels consistent with a postmenopausal or without menstrual-potential state
			Patient has not received prior systemic treatment for metastatic disease
	and ( and	С С	Treatment must be used in combination with an endocrine partner Patient has not received prior funded treatment with a CDK4/6 inhibitor
or			
	and	$\mathcal{O}$	Patient has an active Special Authority approval for ribociclib
	and (	С	Patient has experienced a grade 3 or 4 adverse reaction to ribociclib that cannot be managed by dose reductions and requires treatment discontinuation
	(	С	Treatment must be used in combination with an endocrine partner
	and (	С	There is no evidence of progressive disease since initiation of ribociclib

Prerequisites (tick boxes where appropriate)

Ο

and  $\bigcirc$  Treatment must be used in combination with an endocrine partner

There is no evidence of progressive disease since initiation of palbociclib

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.

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:		

### Ribociclib

	C	Patient has unresectable locally advanced or metastatic breast cancer
	and	There is documentation confirming disease is hormone-receptor positive and HER2-negative
	and	Patient has an ECOG performance score of 0-2
		O Disease has relapsed or progressed during prior endocrine therapy
		Patient is amenorrhoeic, either naturally or induced, with endocrine levels consistent with a postmenopausal or without menstrual-potential state
		O Patient has not received prior systemic endocrine treatment for metastatic disease
	and	Treatment to be used in combination with an endocrine partner
	and	Patient has not received prior funded treatment with a CDK4/6 inhibitor
or	C	Patient has an active Special Authority approval for palbociclib
	and	Patient has experienced a grade 3 or 4 adverse reaction to palbociclib that cannot be managed by dose reductions and requires treatment discontinuation
	C	Treatment must be used in combination with an endocrine partner
	and	There is no evidence of progressive disease since initiation of palbociclib

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

O
and
$\cup$

D Treatment must be used in combination with an endocrine partner

There is no evidence of progressive disease since initiation of ribociclib

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:	

# Lenvatinib

or	O Patient is currently on treatment with lenvatinib and met all remaining criteria prior to commencing treatment			
	and	O The patient has locally advanced or metastatic differentiated thyroid cancer		
			0	Patient must have symptomatic progressive disease prior to treatment
		or	0	Patient must progressive disease at critical anatomical sites with a high risk of morbidity or mortality where local control cannot be achieved by other measures
	and	$\sim$		
O A lesion without iodine uptake in a RAI scan		A lesion without iodine uptake in a RAI scan		
		or	Ο	Receiving cumulative RAI greater than or equal to 600 mCi
		or	Ο	Experiencing disease progression after a RAI treatment within 12 months
		or	Ο	Experiencing disease progression after two RAI treatments administered within 12 months of each other
and Patient has thyroid stimulating hormone (TSH) adequately supressed		ent has thyroid stimulating hormone (TSH) adequately supressed		
	and	$\bigcirc$		
Patient is not a candidate for radiotherapy with curative intent and Surgery is clinically inappropriate				
				and

Prerequisites (tick box where appropriate)

O There is no evidence of disease progression

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:	
Vard: NHI:		
Lenvatinib - continued		
INITIATION – unresectable hepatocellular carcinoma Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)		
<ul> <li>Patient has unresectable hepatocellular carcinoma</li> <li>Patient has preserved liver function (Childs-Pugh A)</li> <li>and</li> <li>Transarterial chemoembolisation (TACE) is unsuitable</li> <li>Patient has an ECOG performance status of 0-2</li> <li>Patient has not received prior systemic therapy for their or</li> <li>Patient has not received prior systemic therapy for their or</li> <li>Patient has experienced treatment-limiting toxicity</li> <li>and</li> <li>No disease progression since initiation of atezolizit</li> </ul> CONTINUATION – unresectable hepatocellular carcinoma Re-assessment required after 6 months Prerequisites (tick box where appropriate) O There is no evidence of disease progression	from treatment with atezolizumab with bevacizumab	
INITIATION – renal cell carcinoma Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)		
O       The patient has metastatic renal cell carcinoma         and       The disease is of predominant clear-cell histology         and       The patient has documented disease progression follow         and       The patient has an ECOG performance status of 0-2         and       Lenvatinib is to be used in combination with everolimus         or       Patient has received funded treatment with nivolumab for         and       Patient has experienced treatment limiting toxicity from t         and       Lenvatinib is to be used in combination with everolimus         or       There is no evidence of disease progression	or the second line treatment of metastatic renal cell carcinoma	
Re-assessment required after 4 months Prerequisites (tick box where appropriate) O There is no evidence of disease progression		
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:	Name:	
Ward:	NHI:	

# Osimertinib

INITIATION – NSCLC – first line Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)
O Patient has locally advanced or metastatic, incurable, non-squamous non-small cell lung cancer (NSCLC)
O Patient is treatment naïve
or O Patient has received prior treatment in the adjuvant setting and/or while awaiting EGFR results or
O The patient has discontinued gefitinib or erlotinib due to intolerance and
O The cancer did not progress while on gefitinib or erlotinib
and O There is documentation confirming that the cancer expresses activating mutations of EGFR and
O Patient has an ECOG performance status 0-3 and
O Baseline measurement of overall tumour burden is documented clinically and radiologically
CONTINUATION – NSCLC – first line         Re-assessment required after 6 months         Prerequisites (tick box where appropriate)         O       Response to or stable disease with treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period
INITIATION – NSCLC – second line Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)
O Patient has locally advanced or metastatic, incurable, non-squamous non-small cell lung cancer (NSCLC)
and O Patient has an ECOG performance status 0-3 and
O The patient must have received previous treatment with erlotinib or gefitinib
O There is documentation confirming that the cancer expresses T790M mutation of EGFR following progression on or after erlotinib or gefitinib
and O The treatment must be given as monotherapy
and O Baseline measurement of overall tumour burden is documented clinically and radiologically

#### CONTINUATION – NSCLC – second line Re-assessment required after 6 months

()

Prerequisites (tick box where appropriate)

Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period

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:	Name:
Ward:	NHI:
Axitinib	
INITIATION Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	e previous line of treatment
The patient has ECOG performance status of 0-2	
CONTINUATION Re-assessment required after 4 months Prerequisites (tick box where appropriate)	

 $\mathbf{O}$ No evidence of disease progression.

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:
Crizotinib	

Re-a		at required after 6 months (tick boxes where appropriate)
	and	Patient has locally advanced or metastatic, unresectable, non-squamous non-small cell lung cancer
	Ο	There is documentation confirming that the patient has a ROS1 rearrangement using an appropriate ROS1 test
	and	Patient has ECOG performance score of 0-3
	and	Baseline measurement of overall tumour burden is documented clinically and radiologically
	TINUATIO	DN

Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)

> and  $\bigcirc$

 $\bigcirc$ Response to treatment has been determined by comparable radiological assessment following the most recent treatment period

No evidence of disease progression.

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:

# Dabrafenib

INITIATION – stage III or IV resected melanoma - adjuvant Re-assessment required after 4 months Prereguisites (tick boxes where appropriate)			
Prerequisites (lick boxes where appropriate)			
O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
O The individual is currently on treatment with dabrafenib and trametinib and met all remaining criteria prior to commencing treatment			
O The individual has resected stage IIIB, IIIC, IIID or IV melanoma (excluding uveal) (see note a) or			
O The individual has received neoadjuvant treatment with a PD-1/PD-L1 inhibitor and			
Adjuvant treatment with dabrafenib is required			
and O The individual has not received prior funded systemic treatment in the adjuvant setting for stage IIIB, IIIC, IIID or IV melanoma and			
O Treatment must be adjuvant to complete surgical resection			
O Treatment must be initiated within 13 weeks of surgical resection, unless delay is necessary due to post-surgery recovery (see note b)			
and O The individual has a confirmed BRAF mutation and			
Dabrafenib must be administered in combination with trametinib			
The individual has ECOG performance score 0-2			
Note:			
a) Stage IIIB, IIIC, IIID or IV melanoma defined as per American Joint Committee on Cancer (AJCC) 8th Edition			

b) Initiating treatment within 13 weeks of complete surgical resection means 13 weeks after resection (primary or lymphadenectomy)

Use this checklist to determine if a patient meets the restrictions for funding in the <b>hospital setting</b> . For more details, refer to Section H of the Pharmaceutical Schedule. For community funding, see the Special Authority Criteria.			
PRESCRIE	BER		PATIENT:
Name:			Name:
Ward:	Ward: NHI:		
Dabrafer	nib - cont	inued	
Re-assess Prerequis	sment requ sites (tick b		ccordance with a protocol or guideline that has been endorsed by the Health
	and and and	No evidence of disease recurrence Dabrafenib must be administered in combination with tra Treatment to be discontinued at signs of disease recurre any systemic neoadjuvant treatment	ametinib ence or at completion of 12 months' total treatment course, including
or	and and and and and and	The individual has received adjuvant treatment with a BI The individual has metastatic or unresectable melanoma The individual meets initiation criteria for dabrafenib for The individual has received adjuvant treatment with a BI The individual has received a BRAF/MEK inhibitor for un	a (excluding uveal) stage III or IV unresectable or metastatic melanoma RAF/MEK inhibitor
	Ō	The individual meets continuation criteria for dabrafenib	for unresectable or metastatic melanoma

			letermine if a patient meets the restrictions for funding in the <b>hospital setting</b> . For more details, refer to Section H of the Pharmaceutical unity funding, see the Special Authority Criteria.
PRES	CRIB	ER	PATIENT:
Name	:		Name:
Ward:			
Dabra	afen	ib - con	tinued
Re-as	ssess quisi	ment req <b>tes</b> (tick	ectable or metastatic melanoma uired after 4 months boxes where appropriate) I by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
and	N		
	or	J The	individual is currently on treatment with dabrafenib and trametinib and met all remaining criteria prior to commencing treatment
		and	The individual has metastatic or unresectable melanoma (excluding uveal) stage III or IV
		0	Baseline measurement of overall tumour burden is documented clinically and radiologically
	The individual has ECOG performance score 0-2		
			The individual has confirmed BRAF mutation
and O Dabrafenib must be administered in combination with trametinib and		Dabrafenib must be administered in combination with trametinib	
			O The individual has been diagnosed in the metastatic or unresectable stage III or IV setting
		0	m O The individual did not receive treatment in the adjuvant setting with a BRAF/MEK inhibitor
			O The individual received treatment in the adjuvant setting with a BRAF/MEK inhibitor and
			O The individual did not experience disease recurrence while on treatment with that BRAF/MEK inhibitor
			The individual did not experience disease recurrence within six months of completing adjuvant treatment with a BRAF/MEK inhibitor
CONTINUATION – unresectable or metastatic melanoma Re-assessment required after 4 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
		or O	The individual's disease has had a complete response to treatment
		or O	The individual's disease has had a partial response to treatment

O The individual has stable disease with treatment

Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period

#### I confirm that the above details are correct:

and

 $\bigcirc$ 

Signed:	Date:
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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:
Trametinib	

# INITIATION - stage III or IV resected melanoma - adjuvant Re-assessment required after 4 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and The individual is currently on treatment with dabrafenib and trametinib and met all remaining criteria prior to commencing treatment or The individual has resected stage IIIB, IIIC, IIID or IV melanoma (excluding uveal) (see note a) or ( ) The individual has received neoadjuvant treatment with a PD-1/PD-L1 inhibitor and ( ) Adjuvant treatment with trametinib is required and The individual has not received prior funded systemic treatment in the adjuvant setting for stage IIIB, IIIC, IIID or IV melanoma and Treatment must be adjuvant to complete surgical resection and Treatment must be initiated within 13 weeks of surgical resection, unless delay is necessary due to post-surgery recovery (see note b) and The individual has a confirmed BRAF mutation and Trametinib must be administered in combination with dabrafenib and The individual has ECOG performance score 0-2 Note: a) Stage IIIB, IIIC, IIID or IV melanoma defined as per American Joint Committee on Cancer (AJCC) 8th Edition

b) Initiating treatment within 13 weeks of complete surgical resection means 13 weeks after resection (primary or lymphadenectomy)

I confirm that the above details are correct:

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

		letermine if a patient meets the restrictions for funding in t unity funding, see the Special Authority Criteria.	he <b>hospital setting</b> . For more details, refer to Section H of the Pharmaceutical
PRESCRI	BER		PATIENT:
Name:			Name:
Ward:			NHI:
Trametir	nib - conti	inued	
Re-asses Prerequis	sment requ sites (tick b		ccordance with a protocol or guideline that has been endorsed by the Health
	and and O	No evidence of disease recurrence Trametinib must be administered in combination with da Treatment to be discontinued at signs of disease recurr any systemic neoadjuvant treatment	ubrafenib ence or at completion of 12 months' total treatment course, including
and O The individual has meta and		The individual has received adjuvant treatment with a B The individual has metastatic or unresectable melanom The individual meets initiation criteria for trametinib for t	a (excluding uveal) stage III or IV
or	and and and	The individual has received adjuvant treatment with a B The individual has received a BRAF/MEK inhibitor for u The individual meets continuation criteria for trametinib	nresectable or metastatic melanoma

		ermine if a patient meets the restrictions for funding in the <b>hospital setting</b> . For more details, refer to Section H of the Pharm ity funding, see the Special Authority Criteria.	aceutical
PRESC	RIBER	PATIENT:	
Name:		Name:	
Ward:		NHI:	
Trame	etinib - a	led	
Re-ass	sessment <b>quisites</b> (t	ctable or metastatic melanoma ed after 4 months xes where appropriate) y, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the	Health
and	NZ Ho		
	or O 1	dividual is currently on treatment with dabrafenib and trametinib and met all remaining criteria prior to commencing treatment	t
	and	The individual has metastatic or unresectable melanoma (excluding uveal) stage III or IV Baseline measurement of overall tumour burden is documented clinically and radiologically The individual has ECOG performance score 0-2	
	and and and	The individual has confirmed BRAF mutation	
		<ul> <li>The individual has been diagnosed in the metastatic or unresectable stage III or IV setting</li> <li>The individual did not receive treatment in the adjuvant setting with a BRAF/MEK inhibitor</li> </ul>	
		<ul> <li>The individual received treatment in the adjuvant setting with a BRAF/MEK inhibitor</li> <li>and</li> <li>The individual did not experience disease recurrence while on treatment with that BRAF/MEK inhibitor</li> <li>and</li> <li>The individual did not experience disease recurrence within six months of completing adjuvant treatment with a BRAF/MEK inhibitor</li> </ul>	
CONTINUATION - unresectable or metastatic melanoma Re-assessment required after 4 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O The individual's disease has had a complete response to treatment			
	or	The individual's disease has had a partial response to treatment	

O The individual has stable disease with treatment

Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period

I confirm that the above details are correct:

and

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:

# Dasatinib

INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)			
O Prescribed by, or recommended by a haematologist or any relevant practitioner on the recommendation of a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
<ul> <li>O The patient has a diagnosis of chronic myeloid leukaemia (CML) in blast crisis or accelerated phase</li> <li>O The patient has a diagnosis of Philadelphia chromosome-positive acute lymphoid leukaemia (Ph+ ALL)</li> </ul>			
or O The patient has a diagnosis of CML in chronic phase and			
<ul> <li>Patient has documented treatment failure* with imatinib</li> <li>Patient has experienced treatment-limiting toxicity with imatinib precluding further treatment with imatinib</li> <li>Patient has high-risk chronic-phase CML defined by the Sokal or EURO scoring system</li> </ul>			
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)			
O Prescribed by, or recommended by a haematologist or any relevant practitioner on the recommendation of a haematologist , or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
<pre>O Lack of treatment failure while on dasatinib* and O Dasatinib treatment remains appropriate and the patient is benefiting from treatment</pre>			
Nater theotheont follows for OML on defined by Louise Met Originalized			

Note: \*treatment failure for CML as defined by Leukaemia Net Guidelines.

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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:
<b>-</b> • • • •	

# Erlotinib

INITIATION Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)			
and	0 0	Patient has locally advanced or metastatic, unresectable, non-squamous Non Small Cell Lung Cancer (NSCLC) There is documentation confirming that the disease expresses activating mutations of EGFR	
	or	<ul> <li>Patient is treatment naive</li> <li>Patient has received prior treatment in the adjuvant setting and/or while awaiting EGFR results</li> <li>The patient has discontinued osimertinib or getitinib due to intolerance</li> <li>and</li> <li>The cancer did not progress while on osimertinib or gefitinib</li> </ul>	

### CONTINUATION

Re-assessment required after 6 months

Prerequisites (tick box where appropriate)

O Radiological assessment (preferably including CT scan) indicates NSCLC has not progressed

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:	Name:		
Ward:	NHI:		
Sunitinib			
INITIATION – RCC Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)			
and O The patient has not previously received funded sunitinib			
CONTINUATION - RCC         Re-assessment required after 4 months         Prerequisites (tick box where appropriate)         O       No evidence of disease progression			
INITIATION – GIST Re-assessment required after 3 months Prerequisites (tick boxes where appropriate)			
And The patient has unresectable or metastatic malignant gastrointer and O The patient's disease has progressed following treatment or O The patient has documented treatment-limiting intolerance	with imatinib		
CONTINUATION – GIST Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)			
The patient has responded to treatment or has stable disease as follows:	s determined by Choi's modified CT response evaluation criteria as		
O The patient has had a complete response (disappearance or O The patient has had a partial response (a decrease in siz (HU) of 15% or more on CT and no new lesions and no c	e of 10% or more or decrease in tumour density in Hounsfield Units bvious progression of non-measurable disease) e two above) and does not have progressive disease and no		
and O The treatment remains appropriate and the patient is benefiting	from treatment		
CONTINUATION – GIST pandemic circumstances Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)			
O The patient has unresectable or metastatic malignant gastrointe and O The patient is clinically benefiting from treatment and continued			

O Sunitinib is to be discontinued at progression

The regular renewal requirements cannot be met due to COVID-19 constraints on the health sector

I confirm that the above details are correct:

and

and

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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:

# Sunitinib - continued

Note: GIST - It is recommended that response to treatment be assessed using Choi's modified CT response evaluation criteria (J Clin Oncol, 2007, 25:1753-1759). Progressive disease is defined as either: an increase in tumour size of 10% or more and not meeting criteria of partial response (PR) by tumour density (HU) on CT; or: new lesions, or new intratumoral nodules, or increase in the size of the existing intratumoral nodules.

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:	
Lapatinib		
INITIATION Prerequisites (tick box where appropriate) O For continuation use only		
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)		
<ul> <li>The patient has metastatic breast cancer expressing HER-2 IF</li> <li>and</li> <li>The cancer has not progressed at any time point during the pro-</li> <li>and</li> <li>Lapatinib not to be given in combination with trastuzumab</li> <li>and</li> <li>Lapatinib to be discontinued at disease progression</li> </ul>		

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:		

# Pazopanib

	Ment required after 3 months tes (tick boxes where appropriate)
	O The patient has metastatic renal cell carcinoma of predominantly clear cell histology
	O The patient is treatment naive
	O The patient has only received prior cytokine treatment
	and O The patient has an ECOG performance score of 0-2 and
	The patient has intermediate or poor prognosis defined as:
	O Lactate dehydrogenase level > 1.5 times upper limit of normal or O Haemoglobin level < lower limit of normal
	or O Corrected serum calcium level > 10 mg/dL (2.5 mmol/L)
	O Interval of < 1 year from original diagnosis to the start of systemic therapy or
	O Karnofsky performance score of less than or equal to 70 or O 2 or more sites of organ metastasis
or	
	O The patient has metastatic renal cell carcinoma
	and O The patient has discontinued sunitinib within 3 months of starting treatment due to intolerance
	and O The cancer did not progress whilst on sunitinib and
	O Pazopanib to be used for a maximum of 3 months
CONTINU Re-assess	ATION ment required after 3 months

**Prerequisites** (tick box where appropriate)

O No evidence of disease progression

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:	Name:		
Ward:	NHI:		

# Gefitinib

	N sment required after 4 months ites (tick boxes where appropriate) O Patient has locally advanced, or metastatic, unresectable, non-squamous Non Small Cell Lung Cancer (NSCLC)
and	or O Patient is treatment naive or O Patient has received prior treatment in the adjuvant setting and/or while awaiting EGFR results or O The view of the set of the
and	$\sim$
	There is documentation confirming that disease expresses activating mutations of EGFR  ATION sment required after 6 months ites (tick box where appropriate)

O Radiological assessment (preferably including CT scan) indicates NSCLC has not progressed

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:		
Dexrazoxane			
INITIATION Brazaguiaitas (tick bayos whore appropriate)			
Drerequisites (tick beyon where expression)			

Fier	cquisi	103	(lick boxes where appropriate)
( and			cribed by, or recommended by a medical oncologist, paediatric oncologist, haematologist or paediatric haematologist, or in accordance with tocol or guideline that has been endorsed by the Health NZ Hospital.
	( and	С	Patient is to receive treatment with high dose anthracycline given with curative intent
	(	С	Based on current treatment plan, patient's cumulative lifetime dose of anthracycline will exceed 250mg/m2 doxorubicin equivalent or greater
	and ( and	С	Dexrazoxane to be administered only whilst on anthracycline treatment
	anu	_	O Treatment to be used as a cardioprotectant for a child or young adult
		or	O Treatment to be used as a cardioprotectant for secondary malignancy
l			

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:		

# Abiraterone acetate

INITIATION Re-assessment required after 6 months Prereguisites (tick boxes where appropriate)				
O and	Presc	cribed by, or recommended by a medical oncologist, radiation oncologist or urologist, or in accordance with a protocol or guideline that has endorsed by the Health NZ Hospital.		
and	C	Patient has prostate cancer		
and	C t	Patient has metastases		
and	C t	Patient's disease is castration resistant		
		O Patient is symptomatic		
		and O Patient has disease progression (rising serum PSA) after second line anti-androgen therapy and		
		O Patient has ECOG performance score of 0-1		
		O Patient has not had prior treatment with taxane chemotherapy		
	or	O Patient's disease has progressed following prior chemotherapy containing a taxane		
		O Patient has ECOG performance score of 0-2		
		O Patient has not had prior treatment with abiraterone		

### CONTINUATION

and

and

and

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Re-assessmen	t required after 6 months	
Prereauisites	(tick boxes where appropriate)	

$\circ$	Prescribed by, or recommended by a medical oncologist, radiation oncologist or urologist, or in accordance with a protocol or guideline that has
and	been endorsed by the Health NZ Hospital.
	2

)	Significant decrease	in serum	PSA from	haseli	ne
/	Significant decrease	III Seruill		Daseili	116

No evidence of clinical disease progression

No initiation of taxane chemotherapy with abiraterone

The treatment remains appropriate and the patient is benefiting from treatment

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:
Abiraterone acetate - continued	
CONTINUATION – pandemic circumstances Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
The patient is clinically benefiting from treatment and continue	ed treatment remains appropriate
O Abiraterone acetate to be discontinued at progression	
No initiation of taxane chemotherapy with abiraterone	
and The regular renewal requirements cannot be met due to COVI	D-19 constraints on the health sector

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:

# Fulvestrant

Re-a		ent required after 6 months <b>s</b> (tick boxes where appropriate)
and		scribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ apital.
	and and	Patient has oestrogen-receptor positive locally advanced or metastatic breast cancer Patient has disease progression following prior treatment with an aromatase inhibitor or tamoxifen for their locally advanced or metastatic disease
	and	Treatment to be given at a dose of 500 mg monthly following loading doses Treatment to be discontinued at disease progression

### CONTINUATION

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

and	0	Prescribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the He Hospital.	ncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ	
		O Treatment remains appropriate and patient is benefitting from treatment		
	an	O Treatment to be given at a dose of 500 mg monthly		
	an	nd		

O No evidence of disease progression

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:	Name:		
Ward:	NHI:		

# Long-acting Somatostatin Analogues

	INITIATION – Malignant bowel obstruction Prerequisites (tick boxes where appropriate)			
	and	0	The patient has nausea* and vomiting* due to malignant bowel obstruction*	
	and	0	Treatment with antiemetics, rehydration, antimuscarinic agents, corticosteroids and analgesics for at least 48 hours has not been successful	
	anu	Ο	Treatment to be given for up to 4 weeks	
Note	: Indie	catio	ns marked with * are unapproved indications	
Re-a	ssess	men	acromegaly It required after 3 months (tick boxes where appropriate)	
	and	Ο	The patient has acromegaly	
			O Treatment with surgery and radiotherapy is not suitable or was unsuccessful	
		or	O Treatment is for an interim period while awaiting the beneficial effects of radiotherapy	
	and	0	Treatment with a dopamine agonist has been unsuccessful	

### **CONTINUATION** – acromegaly

Prerequisites (tick box where appropriate)

O Without reassessment for applications where IGF1 levels have decreased since starting treatment

Note: In patients with acromegaly, treatment should be discontinued if IGF1 levels have no decreased 3 months after treatment. In patients treated with radiotherapy treatment should be withdrawn every 2 years, for 1 month, for assessment of remission. Treatment should be stopped where there is biochemical evidence of remission (normal IGF1 levels) following treatment withdrawal for at least 4 weeks.

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.

ESCRIB	BER		PATIENT:
ne:			Name:
rd:			
ng-act	ting S	Som	matostatin Analogues - continued
			r indications boxes where appropriate)
( or	0 v	/IPoi	omas and glucagonomas - for patients who are seriously ill in order to improve their clinical state prior to definitive surgery
	(and	Ο	Gastrinoma
			O Surgery has been unsuccessful
		or	$^{ m r}$ O Patient has metastatic disease after treatment with H2 antagonist or proton pump inhibitors has been unsuccessful
or	$\square$		
	( and	Ο	Insulinomas
	(	Ο	Surgery is contraindicated or has not been successful
or		Tor n	pre-operative control of hypoglycaemia and for maintenance therapy

O Carcinoid syndrome (diagnosed by tissue pathology and/or urinary 5HIAA analysis) and

O Disabling symptoms not controlled by maximal medical therapy

### **INITIATION** – pre-operative acromegaly

or

Re-assessment required after 12 months

Prere	equisites	(tick boxes where appropriate)
	0	Patient has acromegaly
	and	Patient has a large pituitary tumour, greater than 10 mm at its widest
	and	Patient is scheduled to undergo pituitary surgery in the next six months
Note:	Indicatio	ns marked with * are unapproved indications
		of a long-acting somatostatin analogue in patients with fistulae, oesophageal varices, miscellaneous diarrhoea and hypotension will not be Special Authority

Signed:		Date:	
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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	P	ATIENT:
Name:	N	ame:
Ward:	N	НІ:
Aminolevulinic acid hydrochloride		
INITIATION – high grade malignant glioma Prerequisites (tick boxes where appropriate)		
And Patient has newly diagnosed,	untreated, glioblastoma multiforme	
$\sim$	vant to fluorescence-guided resection	in
O Patient's tumour is amenable	to complete resection	

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.

PRES	CRIB	ER	РАТ	IENT:
Name	:		Nar	e:
Ward:			NHI	
Tacro	olimu	ıs		
		tes (	organ transplant recipients (tick boxes where appropriate)	
	or (		For use in organ transplant recipients The individual is receiving induction therapy for an organ transplant	
			non-transplant indications* (tick boxes where appropriate)	
and		resc ospi	cribed by, or recommended by any specialist, or in accordance with a ital.	protocol or guideline that has been endorsed by the Health NZ
	( and	C	Patient requires long-term systemic immunosuppression	
		<b></b>	O Ciclosporin has been trialled and discontinued treatment beca	ause of unacceptable side effects or inadequate clinical response
		or	O Patient is a child with nephrotic syndrome*	
Note	e: Indi	catio	ons marked with * are unapproved indications	

# RS2062 - Etanercept

Arthritis - rheumatoid - INITIATION Arthritis - rheumatoid - CONTINUATION	
Adult-onset Still's disease - INITIATION	
Adult-onset Still's disease - CONTINUATION Ankylosing spondylitis - INITIATION	
Ankylosing spondylitis - CONTINUATION Oligoarticular course juvenile idiopathic arthritis - INITIATION	
Oligoarticular course juvenile idiopathic arthritis - CONTINUATION	
Polyarticular course juvenile idiopathic arthritis - INITIATION Polyarticular course juvenile idiopathic arthritis - CONTINUATION	
Psoriatic arthritis - INITIATION	
Psoriatic arthritis - CONTINUATION Pyoderma gangrenosum - INITIATION	
Pyoderma gangrenosum - CONTINUATION Severe chronic plaque psoriasis - CONTINUATION	
Severe chronic plaque psoriasis, prior TNF use - INITIATION	
Severe chronic plaque psoriasis, treatment-naive - INITIATION Undifferentiated spondyloarthritis - INITIATION	
Undifferentiated spondyloarthritis - CONTINUATION	

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.

PRES	SCRIBER PATIENT:				
Name	ne: Name:				
Ward	:			NHI:	
Etan	nerce	ept			
Re-a	assess requis	sment sites (t Prescri	requ ick b bed	cular course juvenile idiopathic arthritis ed after 6 months xes where appropriate) y, or recommended by a rheumatologist or named specialist, or in accordance with a protocol or guideline that has been endorsed n NZ Hospital.	
unu		and	Cor	The patient has had an initial Special Authority approval for adalimumab for polyarticular course juvenile idiopathic arthritis JIA) O The patient has experienced intolerable side effects from adalimumab O The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for polyarticular course JIA	
	or	and	O O or	<ul> <li>To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance</li> <li>Patient has had polyarticular course JIA for 6 months duration or longer</li> <li>At least 5 active joints and at least 3 joints with limited range of motion, pain or tenderness after a 3-month trial of methotrexate (at the maximum tolerated dose)</li> <li>Moderate or high disease activity (cJADAS10 score of at least 2.5) after a 3-month trial of methotrexate (at the maximum tolerated dose)</li> <li>Low disease activity (cJADAS10 score between 1.1 and 2.5) after a 6-month trial of methotrexate</li> </ul>	
			_		
Re-a	assess requis	sment <b>sites</b> (t Prescri	requ ick b bed	Iyarticular course juvenile idiopathic arthritis ed after 6 months xes where appropriate) y, or recommended by a rheumatologist or named specialist, or in accordance with a protocol or guideline that has been endorsed n NZ Hospital.	
	and	i		Tent is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or ance Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in obysician's global assessment from baseline	
		or	С	On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline	

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.

PRES	SCRIE	BER		PATIENT:		
Name	:			Name:		
Ward						
Etan	erce	ept-c	ontir	ued		
Re-a	ssess equis	sment re sites (tio	equi ck bo bed l	ticular course juvenile idiopathic arthritis ed after 6 months exes where appropriate) by, or recommended by a rheumatologist or named specialist, or in accordance with a protocol or guideline that has been endorsed h NZ Hospital.		
		and		The patient has had an initial Special Authority approval for adalimumab for oligoarticular course juvenile idiopathic arthritis (JIA) O The patient has experienced intolerable side effects from adalimumab O The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for oligoarticular course JIA		
	or	and		To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance Patient has had oligoarticular course JIA for 6 months duration or longer		
			or or	<ul> <li>At least 2 active joints with limited range of motion, pain or tenderness after a 3-month trial of methotrexate (at the maximum tolerated dose)</li> <li>Moderate or high disease activity (cJADAS10 score greater than 1.5) with poor prognostic features after a 3-month trial of methotrexate (at the maximum tolerated dose)</li> <li>High disease activity (cJADAS10 score greater than 4) after a 6-month trial of methotrexate</li> </ul>		
Re-a	CONTINUATION – oligoarticular course juvenile idiopathic arthritis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a rheumatologist or named specialist, or in accordance with a protocol or guideline that has been endorsed					

by the Health NZ Hospital.

Subsidised as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance

Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baselinee

On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline

()

or

 $\bigcirc$ 

and

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.

RESCRI	BER		PATIENT:
ame:			Name:
ard:			NHI:
anerce	ept - a	conti	nued
rerequis	sment <b>sites</b> (t	requ ick b ibed	tis - rheumatoid ired after 6 months ioxes where appropriate) by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
	and	0	The patient has had an initial Special Authority approval for adalimumab for rheumatoid arthritis
	una	or	O The patient has experienced intolerable side effects
			O The patient has received insufficient benefit to meet the renewal criteria for rheumatoid arthritis
or	and and and and	O O O or	<ul> <li>Patient has had rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic citrullinated peptide (CCP) antibody positive) for six months duration or longer</li> <li>Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance</li> <li>Patient has tried and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated)</li> <li>Patient has tried and not responded to at least three months of methotrexate in combination with sulfasalazine and hydroxychloroquit sulphate at maximum tolerated doses (unless contraindicated)</li> <li>Patient has tried and not responded to at least three months of methotrexate in combination with sulfasalazine and hydroxychloroquit sulphate at maximum tolerated doses (unless contraindicated)</li> <li>Patient has tried and not responded to at least three months of methotrexate in combination with the maximum tolerated dose of ciclosporin</li> <li>Patient has tried and not responded to at least three months of therapy at the maximum tolerated dose of leflunomide alone or in combination with methotrexate</li> <li>Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen joints</li> <li>Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip</li> </ul>
rerequis	sment sites (t Prescri NZ Hos	requ ick b ibed spita	arthritis - rheumatoid ired after 2 years loxes where appropriate) by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health I. ment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or
and	. ii		Following initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician

( and			ribed ospita	by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health I.
	( and	0		ment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or brance
		or	0	Following initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician
			Ο	On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician
	and (	0	Etane	ercept to be administered at doses no greater than 50 mg every 7 days

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							F	PATIENT:
Name: .	ne:						N	Name:
Ward:	rd:						N	NHI:
Etaner	tanercept - continued							
INITIATION – ankylosing spondylitis         Re-assessment required after 6 months         Prerequisites (tick boxes where appropriate)         O       Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Hospital.         and						e with a protocol or guideline that has been endorsed by the Health NZ		
		and		The p	atient has had	an initial Special Author	ity approval fo	or adalimumab for ankylosing spondylitis
			or	0 0	-			from adalimumab alimumab to meet the renewal criteria for adalimumab for
01		and and and		Patie Patie Patie drugs	nt has low back nt has bilateral nt's ankylosing ; (NSAIDs), in c	pain and stiffness that sacroiliitis demonstrated spondylitis has not resp	is relieved by o d by plain radio onded adequa	s present for more than six months exercise but not by rest ographs, CT or MRI scan ately to treatment with two or more non-steroidal anti-inflammatory ndicated, while patient was undergoing at least 3 months of a regular
			or	O O Bath	Bath Ankylosir 4 cm and lumb Patient has lim gender (see N	ng Spondylitis Metrology par side flexion measure itation of chest expansion otes)	r Index (BASM ement of less the set on by at least	n the sagittal and the frontal planes as determined by the following II) measures: a modified Schober's test of less than or equal to han or equal to 10 cm (mean of left and right) 2.5 cm below the average normal values corrected for age and All of at least 6 on a 0-10 scale
measure	Note: The BASDAI must have been determined at the completion of the 3 month exercise trial, but prior to ceasing NSAID treatment. The BASDAI measure must be no more than 1 month old at the time of starting treatment. Average normal chest expansion corrected for age and gender:							
		-	ge		Male	Female		
		18	8-24	Ļ	7.0 cm	5.5 cm		
		2	5-34	Ļ	7.5 cm	5.5 cm		
		3	5-44	ŀ	6.5 cm	4.5 cm		
		4	5-54	Ļ	6.0 cm	5.0 cm		
		5!	5-64	L	5.5 cm	4.0 cm		

65-74

75+

4.0 cm

3.0 cm

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

4.0 cm

2.5 cm

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:
Etanercept - continued	
And Hospital. And Following 12 weeks' initial treatment and for subsequent renew points from pre-treatment baseline on a 10 point scale, or an in and Physician considers that the patient has benefited from treatment and Etanercept to be administered at doses no greater than 50 mg	ent and that continued treatment is appropriate
INITIATION – psoriatic arthritis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a rheumatologist, or in accordan Hospital. and O The patient has had an initial Special Authority approval and O The patient has had an initial Special Authority approval	ce with a protocol or guideline that has been endorsed by the Health NZ for adalimumab or secukinumab for psoriatic arthritis
O The patient has experienced intolerable side effect or O The patient has received insufficient benefit from a adalimumab or secukinumab for psoriatic arthritis	ts from adalimumab or secukinumab
<ul> <li>Patient has had severe active psoriatic arthritis for six m</li> <li>Patient has tried and not responded to at least three moweekly or a maximum tolerated dose</li> </ul>	nths of oral or parenteral methotrexate at a dose of at least 20 mg
or	ed and active disease in at least 15 swollen, tender joints ed and active disease in at least four joints from the following: wrist,
or O Patient has an elevated erythrocyte sedimentation	15 mg/L measured no more than one month prior to the date of this rate (ESR) greater than 25 mm per hour y receiving prednisone therapy at a dose of greater than 5 mg per day

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.

PRES	CRIB	ER			PATIENT:		
Name	:				Name:		
Ward:	/ard:						
Etan	erce	pt -	- conti	nued			
Re-a	CONTINUATION – psoriatic arthritis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)						
O Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.							
	and	or	0	clinically significant response to treatment in the opinion The patient demonstrates at least a continuing 30% impr response to prior etanercept treatment in the opinion of t	rovement in active joint count from baseline and a clinically significant he treating physician		
	O Etanercept to be administered at doses no greater than 50 mg every 7 days						
INITIATION – severe chronic plaque psoriasis, prior TNF use         Re-assessment required after 4 months         Prerequisites (tick boxes where appropriate)         O       Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.							
and	and (		The p	patient has had an initial Special Authority approval for ad	alimumab for severe chronic plaque psoriasis		
			0	The patient has experienced intolerable side effects from	adalimumab		
		or	0	The patient has received insufficient benefit from adalimuplaque psoriasis	umab to meet the renewal criteria for adalimumab for severe chronic		
	and O Patient must be reassessed for continuation after 3 doses						

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.

PRES	CRIE	BER			PATIENT:			
Name	:				Name:			
Ward					NHI:			
Etan	tanercept - continued							
				chronic plaque psoriasis, treatment-naive red after 4 months				
				oxes where appropriate)				
O Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by t Hospital.				e with a protocol or guideline that has been endorsed by the Health NZ				
	(			Patient has "whole body" severe chronic plaque psoriasis with a Psoriasis Area and Severity Index (PASI) score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis				
		been present for at least 6 months from the time of initial	or palm of a hand or sole of a foot, where the plaque or plaques have I diagnosis					
		or	0		aque psoriasis where the plaques or lesions have been present for at a Dermatology Life Quality Index (DLQI) score greater than 10			
	treatment course (but preferably all prior treatment courses), preferably while still on treatment but no longer than cessation of each prior treatment course							
			treatr	PASI assessment or Dermatology Quality of Life Index (DLQI) assessment has been completed for at least the most recent prior atment course (but preferably all prior treatment courses), preferably while still on treatment but no longer than 1 month following station of each prior treatment course				
	and	0	The n	nost recent PASI or DLQI assessment is no more than 1	month old at the time of initiation			
while	Note: "Inadequate response" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 10, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the face, hand, foot, genital or flexural areas at least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very							

face, hand, foot, genital or flexural areas at least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very severe, and for the face, palm of a hand or sole of a foot the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment.

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:		

# Etanercept - continued

#### CONTINUATION – severe chronic plaque psoriasis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)

		and	Patient had "whole body" severe chronic plaque psoriasis at the start of treatment	
			O Following each prior etanercept treatment course the patient has a PASI score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-etanercept treatment baseline value <b>or</b>	
			O Following each prior etanercept treatment course the patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, when compared with the pre-treatment baseline value	
	or			
		and	Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment	
			O Following each prior etanercept treatment course the patient has a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the treatment course baseline values	
			O Following each prior etanercept treatment course the patient has a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-etanercept treatment baseline value	
	or			
		and	Patient had severe chronic localised genital or flexural plaque psoriasis at the start of treatment	
			O The patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline value or	
			O Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing etanercept	
and	$\frown$	Etanerce	ept to be administered at doses no greater than 50 mg every 7 days	
NITIATIO	N – py	oderma/	a gangrenosum	
Prerequis	sites (t	ick boxe	es where appropriate)	
$\bigcirc$	Drooor	ibod by	or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ	
	Hospit		or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ	
and	-			
		Patient h	as pyoderma gangrenosum*	
and				
and	á		has received three months of conventional therapy including a minimum of three pharmaceuticals (e.g. prednisone, ciclosporin, rine, or methotrexate) and not received an adequate response	
	O A maximum of 8 doses			

Note: Indications marked with \* are unapproved indications.

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:							
Etanercept - continued	Etanercept - continued							
CONTINUATION – pyoderma gangrenosum Prerequisites (tick boxes where appropriate)	or in accordance with a protocol or guideline that has been endorsed by the Health NZ							
Hospital. and O The patient has had an initial Speci or O The patient has been started on too and O The patient has experienced intoler	or in accordance with a protocol or guideline that has been endorsed by the Health NZ ial Authority approval for etanercept for adult-onset Still's disease (AOSD) cilizumab for AOSD in a Health NZ Hospital							
or O Patient diagnosed with AOSD according t	to the Yamaguchi criteria (J Rheumatol 1992;19:424-430) least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, non-steroidal thotrexate							
CONTINUATION – adult-onset Still's disease Re-assessment required after 6 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.								

O The patient has a sustained improvement in inflammatory markers and functional status

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.

PRES	SCRIB	BER		PATIENT:
Name	e:			
Ward	:			NHI:
Etan	erce	pt	cont	inued
Re-a	issess <b>equis</b> O F	i <b>tes</b> Presc	t requ (tick b ribed	erentiated spondyloarthritis ired after 6 months poxes where appropriate) by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and	( and	Hosp O O	Patie wrist Patie	Int has undifferentiated peripheral spondyloarthritis* with active peripheral joint arthritis in at least four joints from the following: below, knee, ankle, and either shoulder or hip Int has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a
	and (	0		mum tolerated dose ont has tried and not responded to at least three months of sulfasalazine at a dose of at least 2 g per day (or maximum tolerated )
	and	0	Patie	ent has tried and not responded to at least three months of leflunomide at a dose of up to 20 mg daily (or maximum tolerated dose)
		or	0	Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application
		or	0	Patient has an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour measured no more than one month prior to the date of this application
			0	ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months
Note	: India	catio	ns ma	arked with * are unapproved indications.
Re-a	issess	men	t requ	indifferentiated spondyloarthritis ired after 6 months poxes where appropriate)
		or	0	Applicant is a rheumatologist
			0	Applicant is a Practitioner and confirms that a rheumatologist has provided a letter, email or fax recommending that the patient continues with etanercept treatment
	and	or	0	Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician
			$\mathbf{O}$	The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior etanercept treatment in the opinion of the treating physician
	and	Ο	Etan	ercept to be administered at doses no greater than 50 mg dose every 7 days

## 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:	Name:
Ward:	NHI:

## Bevacizumab

## **INITIATION – Recurrent Respiratory Papillomatosis** Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by an otolaryngologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and () Maximum of 6 doses and The patient has recurrent respiratory papillomatosis and ( ) The treatment is for intra-lesional administration **CONTINUATION – Recurrent Respiratory Papillomatosis** Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) ( ) Prescribed by, or recommended by an otolaryngologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and ( ) Maximum of 6 doses and The treatment is for intra-lesional administration and ()There has been a reduction in surgical treatments or disease regrowth as a result of treatment **INITIATION** – ocular conditions Prerequisites (tick boxes where appropriate)

O Ocular neovascularisation or

Exudative ocular angiopathy

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:	Name:
Ward:	NHI:
Ranibizumab	
INITIATION – Wet Age Related Macular Degeneration	

O f	ites (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 Indorsed by the Health NZ Hospital.
	O Wet age-related macular degeneration (wet AMD)
	or O Polypoidal choroidal vasculopathy
	or 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 or
	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
	and O Patient has not previously been treated with aflibercept for longer than 3 months
or	
(	O Patient has current approval to use aflibercept for treatment of wAMD and was found to be intolerant to aflibercept within 3 months
	ATION – Wet Age Related Macular Degeneration ment required after 12 months
	ites (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 indorsed by the Health NZ Hospital.

I confirm that the above details are correct:

()

and

and

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

Documented benefit must be demonstrated to continue

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

There is no structural damage to the central fovea of the treated eye

## RS2124 - Infliximab

Crohn's disease (adults) - INITIATION	
Crohn's disease (adults) - CONTINUATION	
Crohn's disease (children) - INITIATION	
Crohn's disease (children) - CONTINUATION	
Graft vs host disease - INITIATION	
Inflammatory bowel arthritis (axial) - INITIATION	
Inflammatory bowel arthritis (axial) - CONTINUATION	
Inflammatory bowel arthritis (peripheral) - INITIATION	
Inflammatory bowel arthritis (peripheral) - CONTINUATION	340
Pulmonary sarcoidosis - INITIATION	
Acute fulminant ulcerative colitis - INITIATION	
Ankylosing spondylitis - INITIATION	
Ankylosing spondylitis - CONTINUATION	
Chronic ocular inflammation - INITIATION	
Chronic ocular inflammation - CONTINUATION	
Fistulising Crohn's disease - INITIATION	
Fistulising Crohn's disease - CONTINUATION	
Fulminant ulcerative colitis - CONTINUATION	
Immune checkpoint inhibitor toxicity in malignancy* - INITIATION	
Immune checkpoint inhibitor toxicity in malignancy* - CONTINUATION	
Neurosarcoidosis - INITIATION	
Neurosarcoidosis - CONTINUATION	
Plaque psoriasis - INITIATION	
Plaque psoriasis - CONTINUATION	
Psoriatic arthritis - INITIATION	
Psoriatic arthritis - CONTINUATION	
Pyoderma gangrenosum - INITIATION	
Pyoderma gangrenosum - CONTINUATION	
Rheumatoid arthritis - INITIATION	
Rheumatoid arthritis - CONTINUATION	
Severe Behcet's disease - INITIATION	
Severe Behcet's disease - CONTINUATION	
Severe ocular inflammation - INITIATION	
Severe ocular inflammation - CONTINUATION	
Ulcerative colitis - INITIATION	
Ulcerative colitis - CONTINUATION	

and

and

Form RS2124 July 2025	RESTRICTIONS CHECKLIST	Page 329
Use this checklist to determine if a patient meets th Schedule. For community funding, see the Special	e restrictions for funding in the <b>hospital setting</b> . For more details, refer I Authority Criteria.	to Section H of the Pharmaceutical
PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Infliximab		
INITIATION – Graft vs host disease         Prerequisites (tick box where appropriate)         O       Patient has steroid-refractory acute grafted	t vs. host disease of the gut	
INITIATION – rheumatoid arthritis         Re-assessment required after 4 months         Prerequisites (tick boxes where appropriate)         O       Prescribed by, or recommended by a rhe Hospital.	eumatologist, or in accordance with a protocol or guideline that has bee	en endorsed by the Health NZ

m The patient has had an initial Special Authority approval for adalimumab and/or etanercept for rheumatoid arthritis

The patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept

Following at least a four month trial of adalimumab and/or etanercept, the patient did not meet the renewal criteria for adalimumab and/or etanercept

) Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance

#### **CONTINUATION – rheumatoid arthritis** Re-assessment required after 6 months

()

or

Prerequisites (tick boxes where appropriate)

Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and

(	Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance
and	

Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician

The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician

Infliximab to be administered at doses no greater than 3 mg/kg every 8 weeks

**INITIATION** – ankylosing spondylitis

or

( )

and

Re-assessment required after 3 months

Prerequisites (tick boxes where appropriate)

and		Pres Hosp		by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
	and	0	The	patient has had an initial Special Authority approval for adalimumab and/or etanercept for ankylosing spondylitis
		or	Ο	The patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept
			Ο	Following 12 weeks of adalimumab and/or etanercept treatment, the patient did not meet the renewal criteria for adalimumab and/or etanercept for ankylosing spondylitis

I confirm that the above details are correct:

Signed: Date:	
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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.

PRES	CRIBER		PATIENT:
Name:	:		Name:
Ward:			NHI:
Inflix	imab -	continued	
Re-as	ssessmer	ON – ankylosing spondylitis nt required after 6 months s (tick boxes where appropriate)	
and	~	scribed by, or recommended by a rheumatologist, or in accordan	ce with a protocol or guideline that has been endorsed by the Health NZ
	O	Following 12 weeks of infliximab treatment, BASDAI has impro or by 50%, whichever is less	oved by 4 or more points from pre-infliximab baseline on a 10 point scale,
	Ο	Physician considers that the patient has benefited from treatm	ent and that continued treatment is appropriate
	and	Infliximab to be administered at doses no greater than 5 mg/kg	g every 6-8 weeks
Re-as	ssessmer equisites		ce with a protocol or guideline that has been endorsed by the Health NZ
and	and or	The patient has had an initial Special Authority approval for ad O The patient has experienced intolerable side effects from	lalimumab and/or etanercept and/or secukinumab for psoriatic arthritis in a reasonable trial of adalimumab and/or etanercept and/or secukinumab and/or etanercept and/or secukinumab, the patient did not meet the or secukinumab for psoriatic arthritis.
Re-as	ssessmer equisites	pital.	ce with a protocol or guideline that has been endorsed by the Health NZ s at least a 50% decrease in active joint count from baseline and a
	and	r o v r	rovement in active joint count from baseline and a clinically significant
	0	Infliximab to be administered at doses no greater than 5 mg/kg	g every 8 weeks

Page 331

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:
Infliximab - continued	
INITIATION – severe ocular inflammation	

	( and	С	The patient has had an initial Special Authority approval for adalimumab for severe ocular inflammation
			O The patient has experienced intolerable side effects from adalimumab
		or	O The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for severe ocular inflammation
or		~	
	and	$\mathcal{O}$	Patient has severe, vision-threatening ocular inflammation requiring rapid control
and			O Treatment with high-dose steroids (intravenous methylprednisolone) followed by high dose oral steroids has proven ineffective at controlling symptoms
		or	O Patient developed new inflammatory symptoms while receiving high dose steroids
		or	O Patient is aged under 8 years and treatment with high dose oral steroids and other immunosuppressants has proven ineffective at controlling symptoms
		_	

		Ο	The patient has had a good clinical response following 3 initial doses
	or	0	Following each 12-month treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria $< \frac{1}{2}$ + anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema)
	or	0	Following each 12-month treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old
Noto	Δt	rial w	ithdrawal should be considered after every 24 months of stability unless the patient is deemed to have extremely high risk of irreversible

Note: A trial withdrawal should be considered after every 24 months of stability, unless the patient is deemed to have extremely high risk of irreversible vision loss if infliximab is withdrawn.

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:		
Infliximab - continued			
<b>INITIATION – chronic ocular inflammation</b> Re-assessment required after 4 months			
Prerequisites (tick boxes where appropriate)			

	and		ine p	patient has had an initial Special Authority approval for adalimumab for chronic ocular inflammation
		_	Ο	The patient has experienced intolerable side effects from adalimumab
		or		The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for chronic ocular inflammation
or				
	(	С	Patier loss	nt has severe uveitis uncontrolled with treatment of steroids and other immunosuppressants with a severe risk of vision
	( and	C	loss	
	( and	) or	loss	nt has severe uveitis uncontrolled with treatment of steroids and other immunosuppressants with a severe risk of vision Patient is 18 years or older and treatment with at least two other immunomodulatory agents has proven ineffective
	( and	Cor	loss	
	( and	C or or	loss O O	Patient is 18 years or older and treatment with at least two other immunomodulatory agents has proven ineffective

## **CONTINUATION – chronic ocular inflammation**

Re-assessment required after 12 months

Prerequisites (t	tick boxes where	appropriate)
------------------	------------------	--------------

		0	The patient has had a good clinical response following 3 initial doses			
	or or	0	Following each 12-month treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema)			
	0.	0	Following each 12-month treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old			
	Note: A trial withdrawal should be considered after every 24 months of stability, unless the patient is deemed to have extremely high risk of irreversible vision loss if infliximab is withdrawn.					
INITIATION – Pulmonary sarcoidosis Prerequisites (tick boxes where appropriate)						
	O Patient has life-threatening pulmonary sarcoidosis that is refractory to other treatments and					

O Treatment is to be prescribed by, or has been recommended by, a physician with expertise in the treatment of pulmonary sarcoidosis

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.

PRES	CRIBE	PATIENT:
Name	:	Name:
Ward:		NHI:
Inflix	imab	- continued
Re-as	ssessme equisite	Crohn's disease (adults) ent required after 6 months s (tick boxes where appropriate)
and		scribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health Hospital.
	and	Patient has active Crohn's disease
	o	O Patient has a CDAI score of greater than or equal to 300, or HBI score of greater than or equal to 10
	o	O Patient has extensive small intestine disease affecting more than 50 cm of the small intestine <b>r</b>
	o	O Patient has evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel resection <b>r</b>
		O Patient has an ileostomy or colostomy, and has intestinal inflammation
	and	Patient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators and corticosteroids
Prere ( and	) Pre	s (tick boxes where appropriate) scribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health Hospital.
	o	CDAI score has reduced by 100 points from the CDAI score, or HBI score has reduced by 3 points, from when the patient was initiated on infliximab
	o	CDAI score is 150 or less, or HBI is 4 or less
		O The patient has demonstrated an adequate response to treatment but CDAI score and/or HBI score cannot be assessed
	and	Infliximab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for up to 3 doses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen weeks after completing the last re-induction cycle
Re-as	ssessme	Crohn's disease (children) ent required after 6 months s (tick boxes where appropriate)
and		scribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health Hospital.
	and	Paediatric patient has active Crohn's disease
	o	O Patient has a PCDAI score of greater than or equal to 30
		O Patient has extensive small intestine disease
	and	Patient has tried but experienced an inadequate response to, or intolerable side effects from, prior therapy with immunomodulators and corticosteroids

	_
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.	

PRESC	RIBER	PATIENT:		
Name:		Name:	Name:	
Ward:		NHI:		
Inflixir	mab -	tinued		
Re-ass Prereq	sessmen <b>quisites</b>	- Crohn's disease (children) quired after 2 years < boxes where appropriate) ed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Hea ital.	alth	
and	or or and	<ul> <li>PCDAI score has reduced by 10 points from the PCDAI score when the patient was initiated on infliximab</li> <li>PCDAI score is 15 or less</li> <li>The patient has demonstrated an adequate response to treatment but PCDAI score cannot be assessed</li> <li>liximab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for</li> </ul>		
		to 3 doses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen eks after completing the last re-induction cycle		
Re-ass	sessmen <b>quisites</b>	Ilising Crohn's disease quired after 6 months < boxes where appropriate) ed by, or recommended by a gastroenterologist, or in accordance with a protocol or guideline that has been endorsed by the Health N	NZ	
a	o and	tient has confirmed Crohn's disease		
	or	<ul> <li>Patient has one or more complex externally draining enterocutaneous fistula(e)</li> <li>Patient has one or more rectovaginal fistula(e)</li> </ul>		
	or	Patient has complete peri-anal fistula		
Re-ass	sessmen quisites	- fistulising Crohn's disease quired after 2 years < boxes where appropriate) ed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Hea ital.	alth	
	or	<ul> <li>The number of open draining fistulae have decreased from baseline by at least 50%</li> <li>There has been a marked reduction in drainage of all fistula(e) from baseline (in the case of adult patients, as demonstrated by a reduction in the Fistula Assessment score), together with less induration and patient reported pain</li> </ul>		
	0	liximab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for to 3 doses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen eks after completing the last re-induction cycle		

	checklist to determine if a patient meets the restrictions for funding in the e. For community funding, see the Special Authority Criteria.	the <b>hospital setting</b> . For more details, refer to Section H of the Pharmaceutical
PRESC	RIBER	PATIENT:
Name:		Name:
Ward:		NHI:
Inflixir	nab - continued	
Re-ass Prereq	<ul> <li>FION – acute fulminant ulcerative colitis essment required after 6 weeks uisites (tick boxes where appropriate)</li> <li>Prescribed by, or recommended by a gastroenterologist, or in accor Hospital.</li> </ul>	rdance with a protocol or guideline that has been endorsed by the Health NZ
and	<ul> <li>Patient has acute, fulminant ulcerative colitis</li> <li>Ind</li> <li>Treatment with intravenous or high dose oral corticosteroids</li> </ul>	nas not been successful
Re-ass Prereq	NZ Hospital. O Where maintenance treatment is considered appropriate, infl reassessed every 6 months Infliximab to be administered at doses up to 5 mg/kg every 8	accordance with a protocol or guideline that has been endorsed by the Health iximab should be used in combination with immunomodulators and weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for timent for re-induction. Another re-induction may be considered sixteen
Re-ass Prereq	NZ Hospital. Patient has active ulcerative colitis and O Patients SCCAI is greater than or equal to 4 or O Patients PUCAI score is greater than or equal to 20 and	rable side effects from, prior therapy with immunomodulators and

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.

PRES	PRESCRIBER			PATIENT:
Name	Name:			Name:
Ward	:			NHI:
nflix	kimal	<b>b</b> - cc	ontini	Jed
Re-a	issess <b>equis</b> i O F	ment i ites (ti	requi ick b bed	Icerative colitis ired after 2 years oxes where appropriate) by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health I.
	and (			The SCCAI score has reduced by 2 points or more from the SCCAI score when the patient was initiated on infliximab The PUCAI score has reduced by 30 points or more from the PUCAI score when the patient was initiated on infliximab mab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for 3 doses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen
Re-a	issess <b>equis</b> i O F	N – pla ment i ites (ti Prescri	aque requi ick b	s after completing the last re-induction cycle <b>psoriasis</b> ired after 3 doses oxes where appropriate) by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and	F	and	or	Patient has had an initial Special Authority approval for adalimumab, etanercept or secukinumab for severe chronic plaque psoriasis         O       Patient has experienced intolerable side effects from adalimumab, etanercept or secukinumab         O       Patient has received insufficient benefit from adalimumab, etanercept or secukinumab to meet the renewal criteria for adalimumab, etanercept or secukinumab to received insufficient benefit from adalimumab, etanercept or secukinumab to meet the renewal criteria for adalimumab, etanercept or secukinumab for severe chronic plaque psoriasis
	or		or	<ul> <li>Patient has "whole body" severe chronic plaque psoriasis with a Psoriasis Area and Severity Index (PASI) score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis</li> <li>Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis</li> <li>Patient has severe chronic localised genital or flexural plaque psoriasis where the plaques or lesions have been present for at least 6 months from the time of initial diagnosis.</li> <li>Patient has severe chronic localised genital or flexural plaque psoriasis where the plaques or lesions have been present for at least 6 months from the time of initial diagnosis, and with a Dermatology Life Quality Index (DLQI) score greater than 10</li> </ul>
				Patient has tried, but had an inadequate response (see Note) to, or has experienced intolerable side effects from, at least three of the following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, cyclosporin, or acitretin A PASI assessment has been completed for at least the most recent prior treatment course (but preferably all prior treatment courses), preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course The most recent PASI assessment is no more than 1 month old at the time of initiation

face, hand, foot, genital or flexural areas at least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very severe, and for the face, palm of a hand or sole of a foot the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment.

Signed: D	Date:
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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:

## Infliximab - continued

	and	O Patient had "whole body" severe chronic plaque psoriasis at the start of treatment
		O Following each prior infliximab treatment course the patient has a PASI score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-infliximab treatment baseline value
or	and	O Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment
		<ul> <li>Following each prior infliximab treatment course the patient has a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the treatment course baseline values</li> <li>Following each prior infliximab treatment course the patient has a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-infliximab treatment baseline value</li> </ul>
or	and	O Patient had severe chronic localised genital or flexural plaque psoriasis at the start of treatment
	anu	<ul> <li>O The patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline value</li> <li>O Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing infliximab</li> </ul>

Prerequisites (tick boxes where appropriate) ()Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and  $\bigcirc$ Biopsy consistent with diagnosis of neurosarcoidosis and Patient has CNS involvement ()and  $\bigcirc$ Patient has steroid-refractory disease and () IV cyclophosphamide has been tried or

O Treatment with IV cyclophosphamide is clinically inappropriate

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:
Infliximab - continued	
CONTINUATION – neurosarcoidosis Re-assessment required after 18 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a neurologist, or in Hospital. and or O A withdrawal period has been tried and the patie or O A withdrawal period has been considered I and O There has been a marked reduction in pre- and O There has been an improvement in N or O Marked improvement in other sympton	but would not be clinically appropriate dnisone dose MRI appearances
INITIATION – severe Behcet's disease Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	s significantly impacting the patient's quality of life (see Notes)
or or	eumatologic and/or mucocutaneous symptoms and has not responded adequately to
and O The patient is experiencing significant loss of qua	ality of life
<ul><li>measured using an appropriate quality of life scale such as the</li><li>b) Treatments appropriate for the particular symptoms are those</li></ul>	e that are considered standard conventional treatments for these symptoms, for example ocular symptoms; azathioprine, steroids, thalidomide, interferon alpha and ciclosporin for
CONTINUATION – severe Behcet's disease Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	I treatment with measurably improved quality of life

O Infliximab to be administered at doses no greater than 5 mg/kg every 8 weeks

I confirm that the above details are correct:

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:			
Vard: NHI:				
Infliximab - continued				
and Hospital.	e with a protocol or guideline that has been endorsed by the Health NZ Iuding a minimum of three pharmaceuticals (e.g. prednisone, ciclosporin,			
CONTINUATION – pyoderma gangrenosum         Prerequisites (tick boxes where appropriate)         O       Prescribed by, or recommended by a dermatologist, or in accordance Hospital.         and       O         Patient has shown clinical improvement and O         Patient continues to require treatment and O         A maximum of 8 doses	e with a protocol or guideline that has been endorsed by the Health NZ			
by a physiotherapist and	e			
CONTINUATION – Inflammatory bowel arthritis (axial) Re-assessment required after 2 years Prerequisites (tick box where appropriate) O Where treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10-point scale, or an improvement in BASDAI of 50%, whichever is less				

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.

PRESCRIE	IBER PATIENT:					
Name:	ame: Name:					
Ward:	Vard: NHI:					
Inflixima	ab - continued					
INITIATIO Re-assess	<ul> <li>ON - Inflammatory bowel arthritis (peripheral) ssment required after 6 months isites (tick boxes where appropriate)</li> <li>Patient has a diagnosis of active ulcerative colitis or active Crohn's disease</li> <li>Patient has active arthritis in at least four joints from the following: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder, sternoclavicular</li> <li>Patient has tried and not experienced a response to at least three months of methotrexate or azathioprine at a maximum tolerated dose (unless contraindicated)</li> <li>Patient has tried and not experienced a response to at least three months of sulfasalazine at a maximum tolerated dose (unless contraindicated)</li> </ul>					
CONTINUATION – Inflammatory bowel arthritis (peripheral) Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)						
or	<ul> <li>Following initial treatment, patient has experienced at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician</li> <li>Patient has experienced at least a continuing 30% improvement in active joint count from baseline in the opinion of the treating physician</li> </ul>					
INITIATION - immune checkpoint inhibitor toxicity in malignancy* Re-assessment required after 4 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O The individual requires treatment for moderate to severe autoimmune toxicity following immune checkpoint inhibitor treatment for malignancy and O The individual has received insufficient benefit from use of corticosteroids and						
Re-assess Prerequise and and	<ul> <li>ssment required after 4 months</li> <li>isites (tick boxes where appropriate)</li> <li>Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by th NZ Hospital.</li> <li>O The individual requires treatment for moderate to severe autoimmune toxicity following immune checkpoint inhibitor treatment for malignancy</li> <li>The individual has received insufficient benefit from use of corticosteroids</li> </ul>					

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:		
Infliximab - continued			
CONTINUATION – immune checkpoint inhibitor toxicity in malig Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	gnancy*		
O Prescribed by, or recommended by any relevant practition NZ Hospital.	er, or in accordance with a protocol or guideline that has been endorsed by the Health		
O The individual has shown clinical improvement and and	ongoing treatment is required		
O Infliximab is to be administered at up to 5mg/kg for $\mathfrak{u}$	up to a total of 8 doses		
Note: Indications marked with * are unapproved indications.			

I confirm that the above details are correct:

## RS2125 - Tocilizumab

Rheumatoid Arthritis - INITIATION	
Rheumatoid Arthritis - CONTINUATION	
Rheumatoid Arthritis (patients previously treated with adalimumab or etanercept) - INITIATION	
Adult-onset Still's disease - INITIATION	
Adult-onset Still's disease - CONTINUATION	
Cytokine release syndrome - INITIATION	
Idiopathic multicentric Castleman's disease - INITIATION	
Idiopathic multicentric Castleman's disease - CONTINUATION	
Immune checkpoint inhibitor toxicity in malignancy* - INITIATION	
Immune checkpoint inhibitor toxicity in malignancy* - CONTINUATION	
Moderate to severe COVID-19 - INITIATION	
Polyarticular juvenile idiopathic arthritis - INITIATION	
Polyarticular juvenile idiopathic arthritis - CONTINUATION	
Previous use - INITIATION	
Systemic juvenile idiopathic arthritis - INITIATION	
Systemic juvenile idiopathic arthritis - CONTINUATION	

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:

## Tocilizumab

Re-a	ssess	ment rec	<b>vine release syndrome</b> uired after 3 doses boxes where appropriate)	
	(	<ul> <li>The patient has developed grade 3 or 4 cytokine release syndrome associated with the administration of blinatumomab for the treatment of acute lymphoblastic leukaemia</li> <li>Tocilizumab is to be administered at doses no greater than 8 mg/kg IV for a maximum of 3 doses (if less than 30kg, maximum of 12 mg/kg)</li> </ul>		
	or	and and	The patient is enrolled in the Malaghan Institute of Medical Research ENABLE trial programme The patient has developed CRS or Immune Effector Cell-Associated Neurotoxicity Syndrome (ICANS) following CAR T-Cell therapy for the treatment of relapsed or refractory B-cell non-Hodgkin lymphoma Tocilizumab is to be administered according to the consensus guidelines for CRS or ICANS for CAR T-cell therapy at doses no greater than 8 mg/kg IV for a maximum of 3 doses	
Re-a	ssess	ment rec	ous use uired after 6 months boxes where appropriate)	
( and		Prescribe NZ Hospi	d by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health al.	
	and	O Pat	ent was being treated with tocilizumab prior to 1 February 2019	
		or C	Rheumatoid arthritis Systemic juvenile idiopathic arthritis	
		or or	Adult-onset Still's disease	
		or	Polyarticular juvenile idiopathic arthritis	
			Idiopathic multicentric Castleman's disease	

Use this checklist to determine if a patient meets the restrictions for funding in the <b>hospital setting</b> . For more details, refer to Section H of the Pharmaceutical Schedule. For community funding, see the Special Authority Criteria.							
PRES	PRESCRIBER PATIENT:						
Name	:		Name:				
Ward			NHI:				
Toci	izun	nab	ontinued	_			
Re-a	ssess equis C F	smen s <b>ites</b> Presc	Imatoid Arthritis (patients previously treated with adalimumab or etanercept) juired after 6 months boxes where appropriate) d by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a r guideline that has been endorsed by the Health NZ Hospital. e patient has had an initial Special Authority approval for adalimumab and/or etanercept for rheumatoid arthritis				
	and	or	The patient has experienced intolerable side effects from adalimumab and/or etanercept The patient has received insufficient benefit from at least a three-month trial of adalimumab and/or etanercept such that they do not meet the renewal criteria for rheumatoid arthritis				
	and	or	The patient is seronegative for both anti-cyclic citrullinated peptide (CCP) antibodies and rheumatoid factor				
			m O The patient has been started on rituximab for rheumatoid arthritis in a Health NZ Hospital nd				

The patient has experienced intolerable side effects from rituximab

At four months following the initial course of rituximab the patient has received insufficient benefit such that they do not meet the renewal criteria for rheumatoid arthritis

Ο

 $\bigcirc$ 

or

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.

PRES	CRIB	ER		PATIENT:		
Name	ıme: Name:					
Ward	ard: NHI:					
Toci	izum	nab	- cor	ntinued		
Re-a	ssessi	men	t requ	natoid Arthritis ired after 6 months		
Prer	equisi	tes	(tick b	poxes where appropriate)		
( and				by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.		
	(	С		nt has had severe and active erosive rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic linated peptide (CCP) antibody positive) for six months duration or longer		
	and ( and	C	Tocili	zumab is to be used as monotherapy		
		or	Ο	Treatment with methotrexate is contraindicated		
		U	Ο	Patient has tried and did not tolerate oral and/or parenteral methotrexate		
	and					
			$\bigcirc$	Patient has tried and not responded to at least three months therapy at the maximum tolerated dose of ciclosporin alone or in combination with another agent		
		or	0	Patient has tried and not responded to at least three months therapy at the maximum tolerated dose of leflunomide alone or in combination with another agent		
	and					
		or	0	Patient has persistent symptoms of poorly controlled and active disease in at least 20 active, swollen, tender joints		
			0	Patient has persistent symptoms of poorly controlled and active disease in at least four active joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip		
	and	$\subseteq$	_			
		or	0	Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application		
			0	C-reactive protein levels not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months		
Re-a	INITIATION – systemic juvenile idiopathic arthritis Re-assessment required after 6 months					
Prer	~			poxes where appropriate)		
( and				by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.		
	( and	С	Patie	nt diagnosed with systemic juvenile idiopathic arthritis		
Patient has tried and not responded to a reasonable trial of all of the following, either alone or in combination: oral or parenteral methotrexate; non-steroidal anti-inflammatory drugs (NSAIDs); and systemic corticosteroids						

## 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.

PRES	SCRIE	BER		PATIENT:		
Name	e:			Name:		
Ward	:					
Госі	lizun	nab -	- con	inued		
Re-a	issess equis	sment <b>sites</b> (t Prescri	requ ick b ibed	nset Still's disease red after 6 months oxes where appropriate) oy, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.		
	O The patient has had an initial Special Authority approval for adalimumab and/or etanercept for adult-onset Still's disease (AOSD) or O The patient has been started on tocilizumab for AOSD in a Health NZ Hospital					
		and	or	<ul> <li>O The patient has experienced intolerable side effects from adalimumab and/or etanercept</li> <li>O The patient has received insufficient benefit from at least a three-month trial of adalimumab and/or etanercept such that they do not meet the renewal criteria for AOSD</li> </ul>		
		and	0 0 0	Patient diagnosed with AOSD according to the Yamaguchi criteria (J Rheumatol 1992;19:424-430) Patient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, non-steroidal antiinflammatory drugs (NSAIDs) and methotrexate Patient has persistent symptoms of disabling poorly controlled and active disease		
Re-a	issess <b>equis</b> O F	sment sites (t Prescri	requ ick b ibed	icular juvenile idiopathic arthritis red after 4 months boxes where appropriate) by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.		
		and	0	The patient has had an initial Special Authority approval for both etanercept and adalimumab for polyarticular course juvenile idiopathic arthritis (JIA) The patient has experienced intolerable side effects, or has received insufficient benefit from, both etanercept and adalimumab		
	or	and	0 0	Treatment with a tumour necrosis factor alpha inhibitor is contraindicated Patient has had polyarticular course JIA for 6 months duration or longer To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance		
		and	or or	<ul> <li>At least 5 active joints and at least 3 joints with limited range of motion, pain or tenderness after a 3-month trial of methotrexate (at the maximum tolerated dose)</li> <li>Moderate or high disease activity (cJADAS10 score of at least 2.5) after a 3-month trial of methotrexate (at the maximum tolerated dose)</li> <li>Low disease activity (cJADAS10 score between 1.1 and 2.5) after a 6-month trial of methotrexate</li> </ul>		

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:
Tocilizumab - continued	
INITIATION – idiopathic multicentric Castleman's disease Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a haematologist, rheumatologis or in accordance with a protocol or guideline that has been endorse and O Patient has severe HHV-8 negative idiopathic multicentric Ca and O Treatment with an adequate trial of corticosteroids has proven	stleman's disease
O Tocilizumab to be administered at doses no greater than 8 m	g/kg IV every 3-4 weeks
INITIATION – moderate to severe COVID-19         Re-assessment required after 1 dose         Prerequisites (tick boxes where appropriate)	
<ul> <li>Patient has confirmed (or probable) COVID-19</li> <li>and</li> <li>Oxygen saturation of &lt; 92% on room air, or requiring supplen</li> <li>and</li> <li>Patient is receiving adjunct systemic corticosteroids, or system</li> <li>and</li> <li>Tocilizumab is to be administered at doses no greater than 8n</li> <li>Tocilizumab is not to be administered in combination with bar</li> </ul>	mic corticosteroids are contraindicated mg/kg IV for a maximum of one dose
and protocol or guideline that has been endorsed by the Health NZ Hos O Following 6 months' initial treatment, the patient has at least significant response to treatment in the opinion of the physicial	a 50% decrease in active joint count from baseline and a clinically an east a continuing 30% improvement in active joint count from baseline and
and protocol or guideline that has been endorsed by the Health NZ Hos	hieved at least an American College of Rheumatology paediatric 30%

Forn July 2	<b>n RS2125</b> 025	HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST	Page 34
	his checklist to determine if a patient meets the relation of the second s	estrictions for funding in the <b>hospital setting</b> . For more details, refer to uthority Criteria.	o Section H of the Pharmaceutical
PRES	CRIBER	PATIENT:	
Name	2:	Name:	
Ward		NHI:	
Toci	izumab - continued		
Re-a	protocol or guideline that has been endorse	natologist or Practitioner on the recommendation of a rheumatologist, ed by the Health NZ Hospital. n inflammatory markers and functional status	or in accordance with a
Re-a	TINUATION – polyarticular juvenile idiopathio ssessment required after 6 months equisites (tick boxes where appropriate)	c arthritis	
( and	Prescribed by, or recommended by a rheun protocol or guideline that has been endorse	natologist or Practitioner on the recommendation of a rheumatologist, ed by the Health NZ Hospital.	
	or physician's global assessment O On subsequent reapplications,	treatment, the patient has at least a 50% decrease in active joint cou from baseline the patient demonstrates at least a continuing 30% improvement in a sician's global assessment from baseline	
Re-a	TINUATION – idiopathic multicentric Castlerr ssessment required after 12 months equisites (tick box where appropriate)	nan's disease	
( and	or in accordance with a protocol or guidelin	natologist, rheumatologist or Practitioner on the recommendation of a ne that has been endorsed by the Health NZ Hospital. In patient has a sustained improvement in inflammatory markers and fu	
Re-a	ATION – immune checkpoint inhibitor toxicit ssessment required after 4 months equisites (tick boxes where appropriate)	y in malignancy*	
( and	Prescribed by, or recommended by any rele	evant practitioner, or in accordance with a protocol or guideline that ha	as been endorsed by the Health
	O The individual requires treatment for	moderate to severe autoimmune toxicity following immune checkpoin	t inhibitor treatment for

The individual has received insufficient benefit from use of corticosteroids  $\bigcirc$ 

m O Tocilizumab is to be administered at a maximum dose of 8 mg/kg fortnightly

I confirm that the above details are correct:

malignancy

and

and

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:
Tocilizumab - continued	
CONTINUATION – immune checkpoint inhibitor toxicity in malignancy* Re-assessment required after 4 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in ac NZ Hospital.	ccordance with a protocol or guideline that has been endorsed by the Health
The individual has shown clinical improvement and ongoing transformed and Tocilizumab is to be administered at a maximum dose of 8 mg	
Note: Indications marked with * are unapproved indications.	

I confirm that the above details are correct:

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:
Omalizumab	
INITIATION – severe asthma	

0		cribed by, or recommended by a clinical immunologist or respiratory specialist, or in accordance with a protocol or guideline that has been rsed by the Health NZ Hospital.
an	O	Patient must be aged 6 years or older
an	Ο	Patient has a diagnosis of severe asthma
an	Ο	Past or current evidence of atopy, documented by skin prick testing or RAST
an		Total serum human immunoglobulin E (IgE) between 76 IU/mL and 1300 IU/ml at baseline
		Proven adherence with optimal inhaled therapy including high dose inhaled corticosteroid (budesonide 1,600 mcg per day or fluticasone propionate 1,000 mcg per day or equivalent), plus long-acting beta-2 agonist therapy (at least salmeterol 50 mcg bd or eformoterol 12 mcg bd) for at least 12 months, unless contraindicated or not tolerated
an	or	O Patient has received courses of systemic corticosteroids equivalent to at least 28 days treatment in the past 12 months, unless contraindicated or not tolerated
		O Patient has had at least 4 exacerbations needing systemic corticosteroids in the previous 12 months, where an exacerbation is defined as either documented use of oral corticosteroids for at least 3 days or parenteral steroids
an	Ο	Patient has an Asthma Control Test (ACT) score of 10 or less
all	Ö	Baseline measurements of the patient's asthma control using the ACT and oral corticosteroid dose must be made at the time of application, and again at around 26 weeks after the first dose to assess response to treatment

Re-assessment required after 6 months

and  $\bigcirc$ 

Prerequisites (tick boxes where appropriate)

 $\bigcirc$ Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and

An increase in the Asthma Control Test (ACT) score of at least 5 from baseline Ο

A reduction in the maintenance oral corticosteroid dose or number of exacerbations of at least 50% from baseline

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:	Name:
Ward:	NHI:
Omalizumab - continued	
INITIATION – severe chronic spontaneous urticaria         Re-assessment required after 6 months         Prerequisites (tick boxes where appropriate)         O       Prescribed by, or recommended by a clinical immunologist or dermendorsed by the Health NZ Hospital.         and	natologist, or in accordance with a protocol or guideline that has been
Patient must be aged 12 years or older	
O Patient is symptomatic with Urticaria Activity Sca and O Patient has a Dermatology life quality index (DL	
and	
or <sup>6</sup> weeks	
and	
O Treatment to be stopped if inadequate response* follow	wing 4 doses
Complete response* to 6 doses of omalizumab	
	ررح
CONTINUATION – severe chronic spontaneous urticaria Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a clinical immunologist or derm	natologist, or in accordance with a protocol or guideline that has been
endorsed by the Health NZ Hospital.	
O Patient has previously had a complete response* to 6 doses or	of omalizumab
O Patient has previously had a complete response* to 6 and O Patient has relapsed after cessation of omalizumab th	

Note: \*Inadequate response defined as less than 50% reduction in baseline UAS7 and DLQI score, or an increase in Urticaria Control Test (UCT) score of less than 4 from baseline. Patient is to be reassessed for response after 4 doses of omalizumab. Complete response is defined as UAS7 less than or equal to 6 and DLQI less than or equal to 5; or UCT of 16. Relapse of chronic urticaria on stopping prednisone/ciclosporin does not justify the funding of omalizumab.

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:

## Siltuximab

and

Re-a	<ul> <li>TATION assessment required after 6 months requisites (tick boxes where appropriate)</li> <li>Prescribed by, or recommended by a haematologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.</li> <li>Patient has severe HHV-8 negative idiopathic multicentric Castleman's Disease and Treatment with an adequate trial of corticosteroids has proven ineffective and Siltuximab is to be administered at doses no greater than 11 mg/kg every 3 weeks</li> </ul>
Re-a	NTINUATION assessment required after 12 months requisites (tick box where appropriate) O Prescribed by, or recommended by a haematologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by

the Health NZ Hospital.

The treatment remains appropriate and the patient has sustained improvement in inflammatory markers and functional status

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:

## Obinutuzumab

INITIATION Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)
O Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
<ul> <li>The patient has progressive Binet stage A, B or C CD20+ chronic lymphocytic leukaemia requiring treatment</li> <li>The patient is obinutuzumab treatment naive</li> <li>and</li> <li>The patient is not eligible for full dose FCR due to comorbidities with a score &gt; 6 on the Cumulative Illness Rating Scale (CIRS) or reduced renal function (creatinine clearance &lt; 70mL/min)</li> <li>and</li> <li>Patient has adequate neutrophil and platelet counts* unless the cytopenias are a consequence of marrow infiltration by CLL</li> <li>and</li> <li>Patient has good performance status</li> <li>Obinutuzumab to be administered at a maximum cumulative dose of 8,000 mg and in combination with chlorambucil for a maximum of 6 cycles</li> <li>Note: Chronic lymphocytic leukaemia includes small lymphocytic lymphoma. Comorbidity refers only to illness/impairment other than CLL induced illness/impairment in the patient. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL disease symptoms an higher ECOG (2 or 3) is acceptable where treatment with obinutuzumab is expected to improve symptoms and improve ECOG score to &lt; 2.</li> <li>* greater than or equal to 1.5 × 10<sup>9</sup>/L</li> </ul>
INITIATION – follicular / marginal zone lymphoma         Re-assessment required after 9 months         Prerequisites (tick boxes where appropriate)
or O Patient has follicular lymphoma O Patient has marginal zone lymphoma
<ul> <li>and</li> <li>Patient is refractory to or has relapsed within 12 months of a rituximab containing combined chemo-immunotherapy regimen*</li> <li>and</li> <li>Patient has an ECOG performance status of 0-2</li> <li>and</li> <li>Patient has been previously treated with no more than four chemotherapy regimens</li> <li>and</li> <li>Obinutuzumab to be administered at a maximum dose of 1000 mg for a maximum of 6 cycles in combination with chemotherapy*</li> </ul>
Note: * includes unapproved indications
CONTINUATION – follicular / marginal zone lymphoma

Re-assessment required after 24 months

Prerequisites (tick boxes where appropriate)

()Patient has no evidence of disease progression following obinutuzumab induction therapy and  $\bigcirc$ Obinutuzumab to be administered at a maximum of 1000 mg every 2 months for a maximum of 2 years and O Obinutuzumab to be discontinued at disease progression

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:

## Pertuzumab

Re-a	INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)							
	( and	O The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)						
		or	O Patient is chemotherapy treatment naive					
			O Patient has not received prior treatment for their metastatic disease and has had a treatment free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer					
	and ( and	О	The patient has good performance status (ECOG grade 0-1)					
	and	О	Pertuzumab to be administered in combination with trastuzumab					
	O Pertuzumab maximum first dose of 840 mg, followed by maximum of 420 mg every 3 weeks and							
	O Pertuzumab to be discontinued at disease progression							
Re-a	CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)							
		an	O The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)					
			O The cancer has not progressed at any time point during the previous 12 months whilst on pertuzumab and trastuzumab					
	or	an	O Patient has signs of disease progression					

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:

## Cetuximab

	head and neck cancer, locally advanced s (tick boxes where appropriate)				
and	Patient has locally advanced, non-metastatic, squamous cell cancer of the head and neck				
0	Cisplatin is contraindicated or has resulted in intolerable side effects				
and	Patient has an ECOG performance score of 0-2				
and	To be administered in combination with radiation therapy				
INITIATION – colorectal cancer, metastatic Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)					
0	Patient has metastatic colorectal cancer located on the left side of the colon (see Note)				
and O and	There is documentation confirming disease is RAS and BRAF wild-type				

O Patient has an ECOG performance score of 0-2 and

O Patient has not received prior funded treatment with cetuximab and

O Cetuximab is to be used in combination with chemotherapy

 $\odot\,$  Chemotherapy is determined to not be in the best interest of the patient based on clinician assessment

CONTINUATION – colorectal cancer, metastatic Re-assessment required after 6 months Prerequisites (tick box where appropriate)

or

O No evidence of disease progression

Note: Left-sided colorectal cancer comprises of the distal one-third of the transverse colon, the splenic flexure, the descending colon, the sigmoid colon, or the rectum.

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.

PRES	CRIB	ER		PATIENT:
Name				
Ward:				NHI:
Aflib	erce	pt		
Re-as	ssessr <b>quisi</b>	nent <b>tes</b> (	requ tick b	ge Related Macular Degeneration ired after 3 months oxes where appropriate)
and				by, or recommended by an ophthalmologist or nurse practitioner, or in accordance with a protocol or guideline that has been y the Health NZ Hospital.
		and	or	<ul> <li>Wet age-related macular degeneration (wet AMD)</li> <li>Polypoidal choroidal vasculopathy</li> <li>Choroidal neovascular membrane from causes other than wet AMD</li> </ul>
				<ul> <li>O The patient has developed severe endophthalmitis or severe posterior uveitis following treatment with bevacizumab</li> <li>O There is worsening of vision or failure of retina to dry despite three intraocular injections of bevacizumab four weeks apart</li> </ul>
		and	Ο	There is no structural damage to the central fovea of the treated eye Patient has not previously been treated with ranibizumab for longer than 3 months
	or	or	0 0	Patient has current approval to use ranibizumab for treatment of wAMD and was found to be intolerant to ranibizumab within 3 months Patient has previously* (*before June 2018) received treatment with ranibizumab for wAMD and disease was stable while on treatment
Re-as	ssessr equisi	nent <b>tes</b> (	requ tick b	Vet Age Related Macular Degeneration ired after 12 months oxes where appropriate)
and				by, or recommended by an ophthalmologist or nurse practitioner, or in accordance with a protocol or guideline that has been y the Health NZ Hospital.

Documented	benefit	must	be demo	nstrated	to	continue

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

There is no structural damage to the central fovea of the treated eye

I confirm that the above details are correct:

 $\bigcirc$ 

and

and

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

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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	
INITIATION – Diabetic Macular Oedema Re-assessment required after 4 months         Prerequisites (tick boxes where appropriate)         O       Prescribed by, or recommended by an ophthalmologist or nurse praendorsed by the Health NZ Hospital.         and       O         Patient has centre involving diabetic macular oedema (DMO) and O         Patient's disease is non responsive to 4 doses of intravitreal b and O         Patient has reduced visual acuity between 6/9 – 6/36 with fun and O         Patient has DMO within central OCT (ocular coherence tomog and	ictional awareness of reduction in vision
There is no centre-involving sub-retinal fibrosis or foveal atrop	shy
CONTINUATION – Diabetic Macular Oedema Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by an ophthalmologist or nurse pra endorsed by the Health NZ Hospital.	actitioner, or in accordance with a protocol or guideline that has been
<ul> <li>There is stability or two lines of Snellen visual acuity gain</li> <li>and</li> <li>There is structural improvement on OCT scan (with reduction and</li> <li>Patient's vision is 6/36 or better on the Snellen visual acuity s</li> </ul>	
There is no centre-involving sub-retinal fibrosis or foveal atrop and After each consecutive 12 months treatment with aflibercent	nation has retrialled with at least one injection of bevacizumab and had

no response

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.

PRES	SCRIE	BER	PATIENT:		
Name	e:		Name:		
Ward	:		NHI:		
Secu	ıkinı	uma	ıb		
			severe chronic plaque psoriasis, second-line biologic		
			t required after 4 months (tick boxes where appropriate)		
O Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Hospital.					
	and	0	The patient has had an initial Special Authority approval for adalimumab or etanercept, or has trialled infliximab in a Health NZ Hospital, for severe chronic plaque psoriasis		
			O The patient has experienced intolerable side effects from adalimumab, etanercept or infliximab		
		or	O The patient has received insufficient benefit from adalimumab, etanercept or infliximab		
	and	0	A Psoriasis Area and Severity Index (PASI) assessment or Dermatology Quality of Life Index (DLQI) assessment has been completed for at least the most recent prior treatment course, preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course		
	and	0	The most recent PASI or DQLI assessment is no more than 1 month old at the time of application		
	<b>TIA</b> 11 1				
Re-a	ssess	smen	ON – severe chronic plaque psoriasis, second-line biologic t required after 6 months (tick boxes where appropriate)		
( and	F		bribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ		
		or	O Patient's PASI score has reduced by 75% or more (PASI 75) as compared to baseline PASI prior to commencing secukinumab		
			O Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing secukinumab		
	and	0	Secukinumab to be administered at a maximum dose of 300 mg monthly		

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 Pharmaceutic	cal
Schedule. For community funding, see the Special Authority Criteria.	

PRESCRIBER	PATIENT:				
Name:	Name:				
Ward:	NHI:				
Secukinumab - continued					
INITIATION – severe chronic plaque psoriasis, first-line biologic         Re-assessment required after 4 months         Prerequisites (tick boxes where appropriate)         O       Prescribed by, or recommended by a dermatologist, or in accordance Hospital.         and         O       Patient has "whole body" severe chronic plaque psoriasis 10, where lesions have been present for at least 6 months from the time of initial of the face, been present for at least 6 months from the time of initial diagnosis, and will least 6 months from the time of initial diagnosis, and will and O         Patient has tried, but had an inadequate response (see Note) following (at maximum tolerated doses unless contraindicated doses unless contraindicated of the face of th	or palm of a hand or sole of a foot, where the plaque or plaques have al diagnosis plaque psoriasis where the plaques or lesions have been present for at the a Dermatology Life Quality Index (DLQI) score greater than 10 to, or has experienced intolerable side effects from, at least three of the to; phototherapy, methotrexate, ciclosporin, or acitretin QI) assessment has been completed for at least the most recent prior the north following cessation of each prior treatment course month old at the time of application "Inadequate response" is defined as: for whole body severe chronic plaque on treatment but no longer than 1 month following cessation of the most oot, genital or flexural areas, at least 2 of the 3 PASI symptom sub scores or the face, palm of a hand or sole of a foot the skin area affected is 30% or				
or secukinumab Patient has a Dermatology Quality of Life Index (Index (	75% or more in the skin area affected, or sustained at this level, as				
O Secukinumab to be administered at a maximum dose of 300	ng monthly				

and

and

 $\bigcirc$ 

## 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.

PRES	SCR	IBER			PATIENT:				
Name	e:				Name:				
Ward	:				NHI:				
Seci	Jkir	านทา	<b>ab</b> - a	continued					
				osing spondylitis, second-line biologic ired after 3 months					
Prer	equi	isites	(tick b	ooxes where appropriate)					
and	C	Pres Hos		by, or recommended by a rheumatologist, or in accordance	ce with a protocol or guideline that has been endorsed by the Health NZ				
	O The patient has had an initial Special Authority approval for adalimumab and/or etanercept for ankylosing spondylitis and								
		or	0	The patient has experienced intolerable side effects from	a reasonable trial of adalimumab and/or etanercept				
			0	Following 12 weeks of adalimumab and/or etanercept tra and/or etanercept for ankylosing spondylitis	eatment, the patient did not meet the renewal criteria for adalimumab				
Re-a	isses	ssme	nt requ	nkylosing spondylitis, second-line biologic ired after 6 months poxes where appropriate)					
	С	Pres	cribed	by, or recommended by a rheumatologist, or in accordance	ce with a protocol or guideline that has been endorsed by the Health NZ				

)	Prescribed by, or recommended by a rheumatologist, or in a	ccordance	with a prot	tocol or guideline	that has been	endorsed by the	Health NZ
	Hospital.						
	ر 						Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Hospital.

Ο	Following 12 weeks initial treatment of secukinumab treatment, BASDAI has improved by 4 or more points from pre-secukinumab
	baseline on a 10 point scale, or by 50%, whichever is less

Physician considers that the patient has benefitted from treatment and that continued treatment is appropriate

Secukinumab to be administered at doses no greater than 300 mg monthly

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.	

R		PATIENT:
		Name:
/ard: NHI:		
nab - c	continued	
ient requ es (tick b	uired after 6 months boxes where appropriate)	ance with a protocol or guideline that has been endorsed by the Health NZ
O	Patient has had an initial Special Authority approval fo	r adalimumab, etanercept or infliximab for psoriatic arthritis
or	O Patient has received insufficient benefit from ada	alimumab, etanercept or infliximab to meet the renewal criteria for
and O and O	Patient has tried and not responded to at least three m weekly or a maximum tolerated dose Patient has tried and not responded to at least three m	nonths of oral or parenteral methotrexate at a dose of at least 20 mg nonths of sulfasalazine at a dose of at least 2 g per day or leflunomide at
or		olled and active disease in at least 15 swollen, tender joints olled and active disease in at least four joints from the following: wrist,
and or or	application O Patient has an elevated erythrocyte sedimentation	an 15 mg/L measured no more than one month prior to the date of this on rate (ESR) greater than 25 mm per hour ntly receiving prednisone therapy at a dose of greater than 5 mg per day
	nab - c - psoria ent reques escribed spital. or and or and or and or and or and or and or	nab       - continued         - psoriatic arthritis ent required after 6 months es (tick boxes where appropriate)         escribed by, or recommended by a rheumatologist, or in accorda spital.         O       Patient has had an initial Special Authority approval fo and         O       Patient has experienced intolerable side effects         or       Patient has received insufficient benefit from ada adalimumab, etanercept or infliximab for psoriati         O       Patient has had severe active psoriatic arthritis for six         O       Patient has tried and not responded to at least three m weekly or a maximum tolerated dose         and       O         O       Patient has persistent symptoms of poorly control elbow, knee, ankle, and either shoulder or hip         and       O         O       Patient has a C-reactive protein level greater tha application

	$\cap$	
	$\bigcirc$	Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician
or	0	The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior secukinumab treatment in the opinion of the treating physician

I confirm that the above details are correct:

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:

### Trastuzumab emtansine

$\mathbf{O}$	Patient has early breast cancer expressing HER2 IHC3+ or ISH+
and	Documentation of pathological invasive residual disease in the breast and/or axiliary lymph nodes following completion of surgery
and	
$\mathbf{O}$	Patient has completed systemic neoadjuvant therapy with trastuzumab and chemotherapy prior to surgery
	Disease has not progressed during neoadjuvant therapy
	Patient has left ventricular ejection fraction of 45% or greater
	Adjuvant treatment with trastuzumab emtansine to be commenced within 12 weeks of surgery
and	Trastuzumab emtansine to be discontinued at disease progression
and O	Total adjuvant treatment duration must not exceed 42 weeks (14 cycles)

Prerequisites (tick boxes where appropriate)

( and	С	Patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)
and (	С	Patient has previously received trastuzumab and chemotherapy, separately or in combination
	or	O The patient has received prior therapy for metastatic disease*
		O The patient developed disease recurrence during, or within six months of completing adjuvant therapy*
and ( and	С	Patient has a good performance status (ECOG 0-1)
		O Patient does not have symptomatic brain metastases
	or	O Patient has brain metastases and has received prior local CNS therapy
and	$\subset$	
	or	O Patient has not received prior funded trastuzumab emtansine or trastuzumab deruxtecan treatment
		O Patient has discontinued trastuzumab deruxtecan due to intolerance
		The cancer did not progress while on trastuzumab deruxtecan
and	$\overline{}$	
(	J	Treatment to be discontinued at disease progression

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:		
Trastuzumab emtansine - continued			
CONTINUATION – metastatic breast cancer Re-assessment required after 6 months			
Prerequisites (tick boxes where appropriate)			
O The cancer has not progressed at any time point during the previous approval period whilst on trastuzumab emtansine and			
O Treatment to be discontinued at disease progression			
Note: *Note: Prior or adjuvant therapy includes anthracycline, other chemotherapy, biological drugs, or endocrine therapy.			

I confirm that the above details are correct:

### RS2133 - Rituximab

ABO-incompatible organ transplant - INITIATION	372
ANCA associated vasculitis - INITIATION	
ANCA associated vasculitis - CONTINUATION	
Antibody-mediated organ transplant rejection - INITIATION	372
B-cell acute lymphoblastic leukaemia/lymphoma* - INITIATION	
CD20+ low grade or follicular B-cell NHL - INITIATION	377
CD20+ low grade or follicular B-cell NHL - CONTINUATION	
Chronic lymphocytic leukaemia - INITIATION	
Chronic lymphocytic leukaemia - CONTINUATION	368
Membranous nephropathy - INITIATION	378
Membranous nephropathy - CONTINUATION	378
Neuromyelitis Optica Spectrum Disorder (NMOSD) - INITIATION	374
Neuromyelitis Optica Spectrum Disorder (NMOSD) - CONTINUATION	374
Severe Refractory Myasthenia Gravis - INITIATION	375
Severe Refractory Myasthenia Gravis - CONTINUATION	375
Severe antisynthetase syndrome - INITIATION	
Severe antisynthetase syndrome - CONTINUATION	
Steroid dependent nephrotic syndrome (SDNS) or frequently relapsing nephrotic syndrome (FRNS) - INI	TIATION
373	
Steroid dependent nephrotic syndrome (SDNS) or frequently relapsing nephrotic syndrome (FRNS) - CON	TINUATIO
373	
Steroid resistant nephrotic syndrome (SRNS) - INITIATION	
Steroid resistant nephrotic syndrome (SRNS) - CONTINUATION	
Aggressive CD20 positive NHL - INITIATION	
Aggressive CD20 positive NHL - CONTINUATION	367
Anti-NMDA receptor autoimmune encephalitis - INITIATION	
Anti-NMDA receptor autoimmune encephalitis - CONTINUATION	377
Desensitisation prior to transplant - INITIATION	379
Graft versus host disease - INITIATION	376
Haemophilia with inhibitors - INITIATION	
Haemophilia with inhibitors - CONTINUATION	365
Immune thrombocytopenic purpura (ITP) - INITIATION	369
Immune thrombocytopenic purpura (ITP) - CONTINUATION	
Immunoglobulin G4-related disease (IgG4-RD*) - INITIATION	
Immunoglobulin G4-related disease (IgG4-RD*) - CONTINUATION	
Indolent low-grade lymphomas or bairy cell leukaemia* - INITIATION	366
Indolent, low-grade lymphomas or hairy cell leukaemia* - CONTINUATION	
Pemiphigus* - INITIATION	379
Pemiphigus* - CONTINUATION	380
Post-transplant - INITIATION	365
Post-transplant - CONTINUATION	365
Pure red cell aplasia (PRCA) - INITIATION	
Pure red cell aplasia (PRCA) - CONTINUATION	
Severe chronic inflammatory demyelinating polyneuropathy - INITIATION	
Severe chronic inflammatory demyelinating polyneuropathy - CONTINUATION	376
Severe cold haemagglutinin disease (CHAD) - INITIATION	368
Severe cold haemagglutinin disease (CHAD) - CONTINUATION	368
Thrombotic thrombocytopenic purpura (TTP) - INITIATION	370
Thrombotic thrombocytopenic purpura (TTP) - CONTINUATION	370
Treatment refractory systemic lupus erythematosus (SLE) - INITIATION	372
Treatment refractory systemic lupus erythematosus (SLE) - CONTINUATION	372
Warm autoimmune haemolytic anaemia (warm AIHA) - INITIATION	
Warm autoimmune haemolytic anaemia (warm AIHA) - CONTINUATION	369

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.

RESCRIBER PATIENT:			
ame: Name:			
Ward:	NHI:		
Rituximab (Riximyo)			
INITIATION – haemophilia with inhibitors Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and			
O       Patient has mild congenital haemophilia complicated by inhibit         or       O         or       O         or       O         or       O         Patient has severe congenital haemophilia complicated by inhibit         or       O         Patient has acquired haemophilia			
CONTINUATION – haemophilia with inhibitors Prerequisites (tick boxes where appropriate)			
Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ and O Patient was previously treated with rituximab for haemophilia with inhibitors and O An initial response lasting at least 12 months was demonstrated and O Patient now requires repeat treatment			
INITIATION – post-transplant         Prerequisites (tick boxes where appropriate)			
O The patient has B-cell post-transplant lymphoproliferative disorder* and O To be used for a maximum of 8 treatment cycles Note: Indications marked with * are unapproved indications.			
CONTINUATION – post-transplant Prerequisites (tick boxes where appropriate)			
<ul> <li>The patient has had a rituximab treatment-free interval of 12 m</li> <li>and</li> <li>The patient has B-cell post-transplant lymphoproliferative disor</li> <li>and</li> <li>To be used for no more than 6 treatment cycles</li> </ul>			
Note: Indications marked with * are unapproved indications.			

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:				
Nard: NHI:				
Rituximab (Riximyo) - continued				
INITIATION – indolent, low-grade lymphomas or hairy cell leukaemia* Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)				
To be used for a maximum of 6 treatment cycles	ukaemia* with relapsed disease following prior chemotherapy			
or          O       The patient has indolent, low grade lymphoma or hairy cell leukaemia* requiring first-line systemic chemotherapy         and       O         To be used for a maximum of 6 treatment cycles				
Note: 'Indolent, low-grade lymphomas' includes follicular, mantle, marginal z indication. 'Hairy cell leukaemia' also includes hairy cell leukaemia variant.	one and lymphoplasmacytic/Waldenstrom macroglobulinaemia. *Unapproved			
CONTINUATION – indolent, low-grade lymphomas or hairy cell leukaemia* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)				
The patient has had a rituximab treatment-free interval of 12 months or more and The patient has indolent, low-grade NHL or hairy cell leukaemia* with relapsed disease following prior chemotherapy and To be used for no more than 6 treatment cycles				
Note: 'Indolent, low-grade lymphomas' includes follicular, mantle, marginal zone and lymphoplasmacytic/Waldenstrom macroglobulinaemia. *Unapproved indication. 'Hairy cell leukaemia' also includes hairy cell leukaemia variant.				
INITIATION – aggressive CD20 positive NHL Prerequisites (tick boxes where appropriate)				
C The patient has treatment naive aggressive CD20 posi and C To be used with a multi-agent chemotherapy regimen g and C To be used for a maximum of 8 treatment cycles				
or The patient has aggressive CD20 positive NHL with relapsed disease following prior chemotherapy and To be used for a maximum of 6 treatment cycles Note: 'Aggressive CD20 positive NHL' includes large B-cell lymphoma and Burkitt's lymphoma/leukaemia.				

I confirm that the above details are correct:

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:			
Rituximab (Riximyo) - continued			
CONTINUATION – aggressive CD20 pos Prerequisites (tick boxes where appropria			
The patient has had a rituz	O The patient has had a rituximab treatment-free interval of 12 months or more and _		
O The patient has relapsed refractory/aggressive CD20 positive NHL and			
O To be used with a multi-agent chemotherapy regimen given with curative intent			
To be used for a maximum	of 4 treatment cycles		
Note: 'Aggressive CD20 positive NHL' incl	udes large B-cell lymphoma and Burkitt's lymphoma/leukaemia.		
INITIATION – Chronic lymphocytic leuk	aemia		
Re-assessment required after 12 months <b>Prerequisites</b> (tick boxes where appropriation	ate)		
and	e Binet stage A, B or C chronic lymphocytic leukaemia (CLL) requiring treatment		
O The patient is rituxin	nab treatment naive		
or	O The patient is chemotherapy treatment naive		
	O The patient's disease has relapsed following no more than three prior lines of chemotherapy treatment		
	ent has had a treatment-free interval of 12 months or more if previously treated with fludarabine and		
cycloph	osphamide chemotherapy		
O The patient's diseas	e has relapsed and rituximab treatment is to be used in combination with funded venetoclax		
and			
and	ormance status		
O The patient does no	t have chromosome 17p deletion CLL		
$\sim$	is to be used in combination with funded venetoclax for relapsed/refractory chronic lymphocytic leukaemia		
and Dituring to be administed			
6 treatment cycles	red in combination with fludarabine and cyclophosphamide, bendamustine or venetoclax for a maximum of		
	nt receives full dose fludarabine and cyclophosphamide (orally or dose equivalent intravenous administration), ax		
Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma. A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL disease symptoms a higher ECOG (2 or 3) is acceptable where treatment with rituximab is expected to improve symptoms and improve ECOG score to < 2.			

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:		
/ard:NHI:			
Rituximab (Riximyo) - continued			
CONTINUATION – Chronic lymphocytic leukaemia Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	nent is to be used in combination with funded venetoclax		
<ul> <li>The patient's disease has relapsed following no n</li> <li>and</li> <li>The patient has had an interval of 36 months or n</li> <li>and</li> <li>The patient does not have chromosome 17p dele</li> <li>and</li> </ul>	nore than one prior line of treatment with rituximab for CLL nore since commencement of initial rituximab treatment tion CLL darabine and cyclophosphamide (orally or dose equivalent intravenous		
and C Rituximab to be administered in combination with fludarabine and cyclophosphamide, bendamustine or venetoclax for a maximum of 6 treatment cycles Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma. A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments.			
INITIATION - severe cold haemagglutinin disease (CHAD)         Re-assessment required after 8 weeks         Prerequisites (tick boxes where appropriate)         O       Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.         and			
Patient has cold haemagglutinin disease* and Patient has severe disease which is characterized by symptoms and	natic anaemia, transfusion dependence or disabling circulatory It of 375 mg/m2 of body surface area per week for a total of 4 weeks		
Note: Indications marked with * are unapproved indications.			
CONTINUATION – severe cold haemagglutinin disease (CHAD) Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate)			
and Hospital.	ce with a protocol or guideline that has been endorsed by the Health NZ ekly for 4 weeks) have proven ineffective and treatment with higher		
or $ \begin{array}{c}                                     $			

Note: Indications marked with \* are unapproved indications.

July 202	25	RESTRICTION	NS CHECKLIST
		o determine if a patient meets the restrictions for funding in the numerity funding, see the Special Authority Criteria.	he <b>hospital setting</b> . For more details, refer to Section H of the Pharmaceutical
PRESC	RIBER		PATIENT:
Name:			Name:
Ward:			NHI:
Rituxi	<b>mab</b> (Rixi	imyo) - <i>continued</i>	
Re-ass	sessment re <b>juisites</b> (tio ) Prescrib		ce with a protocol or guideline that has been endorsed by the Health NZ
	and $\bigcirc$ $\bigcirc$ $\overset{\circ}{\overset{\circ}{\overset{\circ}{\overset{\circ}{\overset{\circ}{\overset{\circ}{\overset{\circ}{\overset{\circ}$	atient has warm autoimmune haemolytic anaemia* ne of the following treatments has been ineffective: steroids 5 mg prednisone daily), cytotoxic agents (e.g. cyclophospha	6 (including if patient requires ongoing steroids at doses equivalent to amide monotherapy or in combination), intravenous immunoglobulin at of 375 mg/m2 of body surface area per week for a total of 4 weeks
Note: I	Indications	marked with * are unapproved indications.	
Re-ass Prereq	essment re juisites (tio ) Prescrib Hospital O Pr do or ( and ( and	L · · · ·	
INITIA Re-ass	TION – imr sessment re juisites (tio	mune thrombocytopenic purpura (ITP) equired after 8 weeks ck boxes where appropriate) bed by, or recommended by a haematologist, or in accordance	ce with a protocol or guideline that has been endorsed by the Health NZ
	or		platelet count of less than or equal to 20,000 platelets per microlitre platelet count of 20,000 to 30,000 platelets per microlitre and significant
a	and or or	<ul> <li>Treatment with steroids and splenectomy have been ine</li> <li>Treatment with steroids has been ineffective and splene</li> <li>Other treatments including steroids have been ineffective</li> </ul>	
a	and O Th	ne total rituximab dose used would not exceed the equivaler	nt of 375 mg/m2 of body surface area per week for a total of 4 weeks

Note: Indications marked with \* are unapproved indications.

I confirm that the above details are correct:

Signad	Data:
Signed.	 Dale.

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:	
Rituximab (Riximyo) - continued		
CONTINUATION – immune thrombocytopenic purpura (ITP) Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a haematologist, or in a Hospital.	accordance with a protocol or guideline that has been endorsed by the Health NZ	
and Previous treatment with lower doses of rituximab (10 doses (375 mg/m <sup>2</sup> weekly for 4 weeks) is now plann or	0 mg weekly for 4 weeks) have proven ineffective and treatment with higher ed	
<ul> <li>Patient was previously treated with rituximab for and</li> <li>An initial response lasting at least 12 months wand</li> <li>Patient now requires repeat treatment</li> </ul>		
Note: Indications marked with * are unapproved indications.		
and Hospital.	accordance with a protocol or guideline that has been endorsed by the Health NZ equivalent of 375 mg/m2 of body surface area per week for a total of 4 weeks	
or or	ura* and has experienced progression of clinical symptoms or persistent ocytopenic purpura* with neurological or cardiovascular pathology	
Note: Indications marked with * are unapproved indications.		
CONTINUATION – thrombotic thrombocytopenic purpura (TTP) Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate)		
O Prescribed by, or recommended by a haematologist, or in a Hospital.	accordance with a protocol or guideline that has been endorsed by the Health NZ	
<ul> <li>Patient was previously treated with rituximab for thronand</li> <li>An initial response lasting at least 12 months was de and</li> <li>Patient now requires repeat treatment</li> </ul>		
O The total rituximab dose used would not exceed the equivalent of 375 mg/m2 of body surface area per week for a total of 4 weeks		
Note: Indications marked with * are unapproved indications.		

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Schedule. For community funding, see the Special Authority Criteria.	
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Rituximab (Riximyo) - continued	
INITIATION – pure red cell aplasia (PRCA) Re-assessment required after 6 weeks Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a haematologist, or in a Hospital. and O Patient has autoimmune pure red cell aplasia* associated v Note: Indications marked with * are unapproved indications.	accordance with a protocol or guideline that has been endorsed by the Health NZ with a demonstrable B-cell lymphoproliferative disorder
CONTINUATION – pure red cell aplasia (PRCA) Re-assessment required after 6 weeks Prerequisites (tick box where appropriate)	
Hospital.	accordance with a protocol or guideline that has been endorsed by the Health NZ
<ul> <li>Patient was previously treated with rituximab for pure red ca demonstrated an initial response lasting at least 12 months</li> <li>Note: Indications marked with * are unapproved indications.</li> </ul>	ell aplasia* associated with a demonstrable B-cell lymphoproliferative disorder and
INITIATION – ANCA associated vasculitis Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate)	
O Patient has been diagnosed with ANCA associated va	asculitis*
and The total rituximab dose would not exceed the equiva and	alent of 375 mg/m <sup>2</sup> of body-surface area per week for a total of 4 weeks
O Induction therapy with daily oral or pulse intrave disease after at least 3 months	enous cyclophosphamide has failed to achieve significant improvement of
O Patient has previously had a cumulative dose o cyclophosphamide would result in a cumulative <b>or</b>	of cyclophosphamide $>15$ g or a further repeat 3 month induction course of e dose $>15$ g
O Cyclophosphamide and methotrexate are contra or	raindicated
O Patient is a female of child-bearing potential or	
O Patient has a previous history of haemorrhagic	cystitis, urological malignancy or haematological malignancy
Note: Indications marked with * are unapproved indications.	
CONTINUATION – ANCA associated vasculitis Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate)	
O Patient has been diagnosed with ANCA associated va	asculitis*
and O Patient has previously responded to treatment with rit and	tuximab but is now experiencing an acute flare of vasculitis
	alent of 375 mg/m <sup>2</sup> of body-surface area per week for a total of 4 weeks

Note: Indications marked with \* are unapproved indications.

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:			
Rituximab (Riximyo) - continued				
INITIATION – treatment refractory systemic lupus erythematosus (SLE) Prerequisites (tick boxes where appropriate)				
<ul> <li>Prescribed by, or recommended by a rheumatologist or nephrologist the Health NZ Hospital.</li> <li>and</li> </ul>	t, or in accordance with a protocol or guideline that has been endorsed by			
The patient has severe, immediately life- or organ-threatening				
The disease has proved refractory to treatment with steroids a and	a dose of at least 1 mg/kg			
The disease has relapsed following prior treatment for at least mofetil and high dose cyclophosphamide, or cyclophosphamic and	t 6 months with maximal tolerated doses of azathioprine, mycophenolate de is contraindicated			
Maximum of four 1000 mg infusions of rituximab				
Note: Indications marked with * are unapproved indications.				
CONTINUATION – treatment refractory systemic lupus erythematosus (SLE) Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a rheumatologist or nephrologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  and  Patient's SLE* achieved at least a partial response to the previous round of prior rituximab treatment  and  Patient's SLE* achieved at least a partial response to the previous round of prior rituximab treatment  Maximum of two 1000 mg infusions of rituximab  Note: Indications marked with * are unapproved indications.				
INITIATION – Antibody-mediated organ transplant rejection Prerequisites (tick box where appropriate)				
O Patient has been diagnosed with antibody-mediated organ transplar Note: Indications marked with * are unapproved indications.	nt rejection*			
INITIATION – ABO-incompatible organ transplant           Prerequisites (tick box where appropriate)				
O Patient is to undergo an ABO-incompatible solid organ transplant* Note: Indications marked with * are unapproved indications.				

Use this checklist to determine if a patient meets the restrictions for funding in Schedule. For community funding, see the Special Authority Criteria.	the <b>hospital setting</b> . For more details, refer to Section H of the Pharmaceutical
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Rituximab (Riximyo) - continued	
	e with a protocol or guideline that has been endorsed by the Health NZ
Hospital.	
O Patient is a child with SDNS* or FRNS* and	
	been ineffective or associated with evidence of steroid toxicity
O Treatment with ciclosporin for at least a period of 3 months h	as been ineffective and/or discontinued due to unacceptable side effects
Treatment with mycophenolate for at least a period of 3 mont	hs with no reduction in disease relapses
O The total rituximab dose used would not exceed the equivale	nt of 375 mg/m <sup>2</sup> of body surface area per week for a total of 4 weeks
Note: Indications marked with a * are unapproved indications.	
Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a nephrologist, or in accordanc Hospital. and	e with a protocol or guideline that has been endorsed by the Health NZ
O Patient who was previously treated with rituximab for nephrot	ic syndrome*
and O Treatment with rituximab was previously successful and has relapsed and the patient now requires repeat treatment and	demonstrated sustained response for > 6 months, but the condition has
$\sim$	nt of 375 mg/m <sup>2</sup> of body surface area per week for a total of 4 weeks
Note: Indications marked with a * are unapproved indications.	
Hospital.	e with a protocol or guideline that has been endorsed by the Health NZ
and O Patient is a child with SRNS* where treatment with steroids a and O Treatment with tacrolimus for at least 3 months has been ine	
and Genetic causes of nephrotic syndrome have been excluded and The total rituring data used would not exceed the equivale	$rt of 0.75$ , $ma/m^2$ of body surface area particularly for a total of 4 was be
Note: Indications marked with a * are unapproved indications.	nt of 375 mg/m <sup>2</sup> of body surface area per week for a total of 4 weeks

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.

PRES	CRIBER		PATIENT:
Name	lame: Name:		
Ward	Vard: NHI:		
Ritu	<b>kimab</b> (F	Riximyo) - <i>continued</i>	
Re-a	ssessmen equisites		with a protocol or guideline that has been endorsed by the Health NZ
	and and	condition has relapsed and the patient now requires repeat tre	emonstrated sustained response for greater than 6 months, but the
Re-a	ssessmen	Neuromyelitis Optica Spectrum Disorder (NMOSD) t required after 6 months (tick boxes where appropriate)	
	and	weekly for four weeks	late
Re-a	ssessmen	DN – Neuromyelitis Optica Spectrum Disorder (NMOSD) t required after 2 years (tick boxes where appropriate) One of the following dose regimens is to be used: 2 doses of weekly for four weeks The patients has responded to the most recent course of rituxi The patient has not received rituximab in the previous 6 month	

#### I confirm that the above details are correct:

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 PATI		ER	PATIENT:	
Name: Name:			Name:	
Ward:	rd: NHI:			
Rituxi	mal	<b>b</b> (R	Riximyo) - <i>continued</i>	
Re-ass	sessr	men	Severe Refractory Myasthenia Gravis t required after 2 years (tick boxes where appropriate)	
and		resc osp	cribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.	
a	( and	С	One of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg once weekly for four weeks, or two 1,000 mg doses given two weeks apart	
		or	O Treatment with corticosteroids and at least one other immunosuppressant for at least a period of 12 months has been ineffective	
			O Treatment with at least one other immunosuppressant for a period of at least 12 months and	
			O Corticosteroids have been trialed for at least 12 months and have been discontinued due to unacceptable side effects	
		or or	<ul> <li>cribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.</li> <li>One of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg once weekly for four weeks, or two 1,000 mg doses given two weeks apart.</li> <li>An initial response lasting at least 12 months was demonstrated</li> <li>O The patient has relapsed despite treatment with corticosteroids and at least one other immunosuppressant for a period of at least 12 months.</li> <li>O The patient's myasthenia gravis has relapsed despite treatment with at least one immunosuppressant for a period of at least 12 months.</li> <li>O Corticosteroids have been trialed for at least 12 months and have been discontinued due to unacceptable side effects.</li> </ul>	
Re-ass	sessr	men	Severe antisynthetase syndrome t required after 12 months (tick boxes where appropriate)	
a	and	) )	Patient has confirmed antisynthetase syndrome Patient has severe, immediately life or organ threatening disease, including interstitial lung disease	
a	and		O Treatment with at least 3 immunosuppressants (oral steroids, cyclophosphamide, methotrexate, mycophenolate, ciclosporin, azathioprine) has not be effective at controlling active disease	
		or	O Rapid treatment is required due to life threatening complications	
a	and	С	Maximum of four 1,000 mg infusions of rituximab	

041y 2020	n Eo mio none	
	slist to determine if a patient meets the restrictions for funding in the community funding, see the Special Authority Criteria.	hospital setting. For more details, refer to Section H of the Pharmaceutical
PRESCRIBER	3	PATIENT:
Name:		lame:
Ward:		IHI:
Rituximab (	(Riximyo) - continued	
CONTINUATI	ION – Severe antisynthetase syndrome	
	ent required after 12 months s (tick boxes where appropriate)	
O	Patient's disease has responded to the previous rituximab treatr strength and pulmonary function	nent with demonstrated improvement in inflammatory markers, muscle
and O and	The patient has not received rituximab in the previous 6 months	
	Maximum of two cycles of 2 × 1,000 mg infusions of rituximab g	ven two weeks apart
	- graft versus host disease s (tick boxes where appropriate)	
and	Patient has refractory graft versus host disease following transp	ant
and	Treatment with at least 3 immunosuppressants (oral steroids, circontrolling active disease	closporin, tacrolimus, mycophenolate, sirolimus) has not be effective at
	The total rituximab dose used would not exceed the equivalent of	of 375 mg/m <sup>2</sup> of body surface area per week for a total of 4 weeks
Prerequisites O Pres Hosp	ent required after 6 months s (tick boxes where appropriate) scribed by, or recommended by a neurologist, or in accordance wit spital.	h a protocol or guideline that has been endorsed by the Health NZ
and O and	Patient has severe chronic inflammatory demyelinating polyneur	opathy (CIPD)
	O Treatment with steroids and intravenous immunoglo active disease	bulin and/or plasma exchange has not been effective at controlling
		namide, ciclosporin, tacrolimus, mycophenolate) has not been
o	O Rapid treatment is required due to life threatening complic	ations
and	One of the following dose regimens is to be used: 375 mg/m2 o weekly for four weeks, or two 1,000 mg doses given two weeks	f body surface area per week for a total of four weeks, or 500 mg once apart
Re-assessme	ION – severe chronic inflammatory demyelinating polyneuropa ent required after 6 months s (tick boxes where appropriate)	athy
Ο	Patient's disease has responded to the previous rituximab treatr compared to baseline	nent with demonstrated improvement in neurological function
and O and	The patient has not received rituximab in the previous 6 months	
0	One of the following dose regimens is to be used: 375 mg/m2 o weekly for four weeks, or two 1,000 mg doses given two weeks	f body surface area per week for a total of four weeks, or 500 mg once apart

I confirm that the above details are correct:

Signed:	. Date:
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		cklist to determine if a patient meets the restrictions for funding or community funding, see the Special Authority Criteria.	g in the <b>hospital setting</b> . For more details, refer to Section H of the Pharmaceutica
PRE	SCRIBE	ER	PATIENT:
Name:			Name:
Nard	ł:		NHI:
Ritu	ximab	<b>0</b> (Riximyo) - <i>continued</i>	
<b>INIT</b> Re-a	TIATION assessm requisit	I – anti-NMDA receptor autoimmune encephalitis ment required after 6 months tes (tick boxes where appropriate)	ance with a protocol or guideline that has been endorsed by the Health NZ
and	Ho	ospital.	
	and	D Patient has severe anti-NMDA receptor autoimmune enc	ephalitis
		O Treatment with steroids and intravenous imm active disease and	nunoglobulin and/or plasma exchange has not been effective at controlling
		effective at controlling active disease	ophosphamide, ciclosporin, tacrolimus, mycophenolate) has not been
		O Rapid treatment is required due to life threatening	complications
	and	One of the following dose regimens is to be used: 375 m weekly for four weeks, or two 1,000 mg doses given two	ng/m2 of body surface area per week for a total of four weeks, or 500 mg once weeks apart
Re-a Prer	assessm r <b>equisit</b> O Pr	ATION – anti-NMDA receptor autoimmune encephalitis ment required after 6 months tes (tick boxes where appropriate) rescribed by, or recommended by a neurologist, or in accorda ospital.	nce with a protocol or guideline that has been endorsed by the Health NZ
and	and	D Patient's disease has responded to the previous rituxima	b treatment with demonstrated improvement in neurological function
	C	${\sf O}$ The patient has not received rituximab in the previous 6 r	months
	and	The patient has experienced a relapse and now requires	further treatment
	and	One of the following dose regimens is to be used: 375 m weekly for four weeks, or two 1,000 mg doses given two	ng/m2 of body surface area per week for a total of four weeks, or 500 mg once weeks apart
Re-a	assessm	I – CD20+ low grade or follicular B-cell NHL ment required after 9 months tes (tick boxes where appropriate)	
Re-a	assessm requisit	nent required after 9 months tes (tick boxes where appropriate)	II NHL with relapsed disease following prior chemotherapy
Re-a	assessm requisit	nent required after 9 months tes (tick boxes where appropriate) O The patient has CD20+ low grade or follicular B-ce	II NHL with relapsed disease following prior chemotherapy
Re-a	assessm requisit	nent required after 9 months tes (tick boxes where appropriate) O The patient has CD20+ low grade or follicular B-ce and	

Use this checklist to determine if a patient meets the restrictions for funding in Schedule. For community funding, see the Special Authority Criteria.	the <b>hospital setting</b> . For more details, refer to Section H of the Pharmaceutical
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Rituximab (Riximyo) - continued	
CONTINUATION – CD20+ low grade or follicular B-cell NHL	
Re-assessment required after 24 months <b>Prerequisites</b> (tick boxes where appropriate)	
A Rituximab is to be used for maintenance in CD20+ low grade chemotherapy and	e or follicular B-cell NHL following induction with first-line systemic
O Patient is intended to receive rituximab maintenance therapy 12 cycles)	for 2 years at a dose of 375 mg/m2 every 8 weeks (maximum of
INITIATION – Membranous nephropathy Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate)	
measures (see Note)	
CONTINUATION – Membranous nephropathy Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate)	
O Patient was previously treated with rituximab for membranou and	s nephropathy*
O Treatment with rituximab was previously successful, but treatment	It the condition has relapsed, and the patient now requires repeat
O Patient achieved partial response to treatment and req	uires repeat treatment (see Note)
and O The total rituximab dose used would not exceed the equivale	ent of 375 mg/m2 of body surface area per week for a total of 4 weeks
Note: a) Indications marked with * are unapproved indications.	
b) High risk of progression to end-stage kidney disease defined as > 5g/day	r proteinuria.
<ul> <li>c) Conservative measures include renin-angiotensin system blockade, bloo dyslipidaemia, and anticoagulation agents unless contraindicated or the</li> </ul>	d-pressure management, dietary sodium and protein restriction, treatment of patient has experienced intolerable side effects.
d) Partial response defined as a reduction of proteinuria of at least 50% from	n baseline, and between 0.3 grams and 3.5 grams per 24 hours.

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.

PRESCRIE	IBER	PATIENT:
Name:		Name:
Ward:		NHI:
Rituxima	ab (Riximyo) - continued	
	ON – B-cell acute lymphoblastic leukaemia/lymphoma*	
	ssment required after 2 years <b>isites</b> (tick boxes where appropriate)	
and	O Patient has newly diagnosed B-cell acute lymphoblastic leukae	emia/lymphoma*
and	O Treatment must be in combination with an intensive chemother	apy protocol with curative intent
	O The total rituximab dose would not exceed the equivalent of 37	5 mg/m2 per dose for a maximum of 18 doses
Note: Indi	dications marked with * are unapproved indications.	
Re-assess	<b>ON – desensitisation prior to transplant</b> ssment required after 6 weeks <b>isites</b> (tick boxes where appropriate)	
and	<ul> <li>Patient requires desensitisation prior to mismatched allogenic</li> <li>Patient would receive no more than two doses at 375 mg/m2 or</li> </ul>	
Note: Indi	dications marked with * are unapproved indications.	
Re-assess Prerequis		alist, or in accordance with a protocol or guideline that has been endorsed
and	by the Health NZ Hospital.	
	O Patient has severe rapidly progressive pemphigus	
	O Is used in combination with systemic corticosteroids (20 and	mg/day)
	O Skin involvement is at least 5% body surface area	sal erosions) or diffuse gingivitis or confluent large erosions
	or O Involvement of two or more mucosal sites	
or		
	O Patient has pemphigus and	
	$\sim$	m systemic corticosteroids (20 mg/day) in combination with a steroid
Note: Indi	dications marked with * are unapproved indications.	

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:
Rituximab (Riximyo) - continued	
CONTINUATION – pemiphigus* Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a dermatologist or relevant speci by the Health NZ Hospital.	alist, or in accordance with a protocol or guideline that has been endorsed
O Patient has experienced adequate clinical benefit from rituxima ulceration and reduction in corticosteroid requirement and	ab treatment, with improvement in symptoms and healing of skin
O Patient has not received rituximab in the previous 6 months	
Note: Indications marked with * are unapproved indications.	
INITIATION – immunoglobulin G4-related disease (IgG4-RD*) Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate)	
O Patient has confirmed diagnosis of IgG4-RD*	
O Treatment with corticosteroids and/or disease modifying lowering corticosteroid dose below 5 mg per day (predn	anti-rheumatic drugs for at least 3 months has been ineffective in isone equivalent) without relapse anti-rheumatic drugs is contraindicated or associated with evidence of
toxicity or intolerance	
and O Total rituximab dose used should not exceed a maximum of tw	o 1000 mg infusions of rituximab given two weeks apart
Note: Indications marked with * are unapproved indications.	
CONTINUATION – immunoglobulin G4-related disease (IgG4-RD*) Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
but the condition has relapsed	uccessful and patient's disease has demonstrated sustained response,
O Patient is receiving maintenance treatment for IgG4-RD*	•
and O Rituximab re-treatment not to be given within 6 months of prev and	
O Maximum of two 1000 mg infusions of rituximab given two wee	eks apart
Note: Indications marked with * are unapproved indications.	

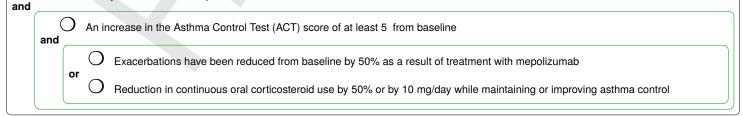
Use this checklist to determine if a patient meets the restrictions for funding in the hospital setting	. For more details,	refer to Section H of the	Pharmaceutical
Schedule. For community funding, see the Special Authority Criteria.			

ESCRIBER	PATIENT:
me:	Name:
ırd:	NHI:
polizumab	
ITIATION – Severe eosinophilic asthma e-assessment required after 12 months rerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a respiratory physician or endorsed by the Health NZ Hospital.	r clinical immunologist, or in accordance with a protocol or guideline that has been
O Patient must be aged 12 years or older and	
	sthma documented by a respiratory physician or clinical immunologist
Conditions that mimic asthma eg. vocal cord dysfunctions	ion, central airway obstruction, bronchiolitis etc. have been excluded
Patient has a blood eosinophil count of greater than 0.8	5 × 10 <sup>°</sup> 9 cells/L in the last 12 months
of fluticasone propionate) plus long acting beta-2 agon therapy regimen, unless contraindicated or not tolerate	including inhaled corticosteroids (equivalent to at least 1000 mcg per day nist, or budesonide/formoterol as part of the single maintenance and reliever ed
and O Patient has had at least 4 exacerbations needing defined as either documented use of oral corticol	g systemic corticosteroids in the previous 12 months, where an exacerbation is steroids for at least 3 days or parenteral corticosteroids
	pids of at least the equivalent of 10 mg per day over the previous 3 months
and O Treatment is not to be used in combination with subsidi	lised benralizumab
O Patient has an Asthma Control Test (ACT) score of 10 and oral corticosteroid dose must be made at the time response to treatment	or less. Baseline measurements of the patient's asthma control using the ACT of application, and again at around 52 weeks after the first dose to assess
and O Patient has not previously received an anti-IL5 bi	iological therapy for their severe eosinophilic asthma
O Patient was refractory or intolerant to previ	ious anti-IL5 biological therapy
	ent with previous anti-IL5 biological therapy and discontinued within

#### CONTINUATION – Severe eosinophilic asthma Re-assessment required after 2 years

Prerequisites (tick boxes where appropriate)

$\cup$	Prescribed by, or recommended by a respiratory physician or clinical immunologist, or in accordance with a protocol or guideline that has been
	endorsed by the Health NZ Hospital.
nd	



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:
Mepolizumab - continued	
INITIATION – eosinophilic granulomatosis with polyangiitis           Re-assessment required after 12 months           Prerequisites (tick boxes where appropriate)	
<ul> <li>The patient has eosinophilic granulomatosis with polyangiitis</li> <li>and</li> <li>The patient has trialled and not received adequate benefit from contraindicated to all): azathioprine, cyclophosphamide, leflue</li> <li>and</li> </ul>	m at least one of the following for at least three months (unless nomide, methotrexate, mycophenolate, or rituximab
	ee months and is unable to maintain disease control at doses below
CONTINUATION – eosinophilic granulomatosis with polyangiitis Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Patient has no evidence of clinical disease progression	

I confirm that the above details are correct:

# RS2063 - Adalimumab (Amgevita)

Arthritis - oligoarticular course juvenile idiopathic - INITIATION	392
Arthritis - oligoarticular course juvenile idiopathic - CONTINUATION	
Arthritis - polyarticular course juvenile idiopathic - INITIATION	
Arthritis - polyarticular course juvenile idiopathic - CONTINUATION	
Arthritis - psoriatic - INITIATION	
Arthritis - psoriatic - CONTINUATION	
Arthritis - rheumatoid - INITIATION	
Arthritis - rheumatoid - CONTINUATION	
Behcet's disease - severe - INITIATION	
Crohn's disease - adults - INITIATION	
Crohn's disease - adults - CONTINUATION	
Crohn's disease - children - INITIATION	
Crohn's disease - children - CONTINUATION	
Crohn's disease - fistulising - INITIATION	
Crohn's disease - fistulising - CONTINUATION	
Hidradenitis suppurativa - INITIATION	
Hidradenitis suppurativa - CONTINUATION	
Ocular inflammation - chronic - INITIATION	
Ocular inflammation - chronic - CONTINUATION	
Ocular inflammation - severe - INITIATION	
Ocular inflammation - severe - CONTINUATION	
Plaque psoriasis - severe chronic - INITIATION	
Plaque psoriasis - severe chronic - CONTINUATION	
Still's disease - adult-onset (AOSD) - INITIATION	
Ankylosing spondylitis - INITIATION	
Ankylosing spondylitis - CONTINUATION	
Inflammatory bowel arthritis - axial - INITIATION	
Inflammatory bowel arthritis - axial - CONTINUATION	
Inflammatory bowel arthritis – peripheral - INITIATION	
Inflammatory bowel arthritis – peripheral - CONTINUATION	
Inflammatory bowel arthritis – peripheral - CONTINUATION Pyoderma gangrenosum - INITIATION Ulcerative colitis - INITIATION	
Ulcerative colitis - INITIATION	
Ulcerative colitis - CONTINUATION	
Undifferentiated spondyloarthiritis - INITIATION	
Undifferentiated spondyloarthiritis - CONTINUATION	
	)

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:

### Adalimumab (Amgevita)

### INITIATION – Behcet's disease - severe Prerequisites (tick boxes where appropriate)

O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

	and (	С	The p	patient has severe Behcet's disease* that is significantly impacting the patient's quality of life
		<b></b>	0	The patient has severe ocular, neurological, and/or vasculitic symptoms and has not responded adequately to one or more treatment(s) appropriate for the particular symptom(s)
		or	0	The patient has severe gastrointestinal, rheumatological and/or mucocutaneous symptoms and has not responded adequately to two or more treatments appropriate for the particular symptom(s)
lote:	Indic	atio	ns ma	rrked with * are unapproved indications.

INITIATION – Hidradenitis suppurativa

Re-assessment required	after 4	months

Prerequisites (tick boxes where appropriate)

( and		Preso Hosp	cribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.
		O	Patient has hidradenitis suppurativa Hurley Stage II or Hurley Stage III lesions in distinct anatomic areas
	anc	O	Patient has tried, but had an inadequate response to at least a 90 day trial of systemic antibiotics or patient has demonstrated intolerance to or has contraindications for systemic antibiotics
	anc	Ο	Patient has 3 or more active lesions
		0	The patient has a DLQI of 10 or more and the assessment is no more than 1 month old at time of application

			ON – Hidradenitis suppurativa nt required after 2 years
F	Prere	quisites	s (tick boxes where appropriate)
a	( Ind		scribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health Hospital.
		Ο	The patient has a reduction in active lesions (e.g. inflammatory nodules, abscesses, draining fistulae) of 25% or more from baseline
		and	The patient has a DLQI improvement of 4 or more from baseline

I confirm that the above details are correct:

Use this checklist to determine if a patient meets the restrictions for funding in th Schedule. For community funding, see the Special Authority Criteria.	e <b>hospital setting</b> . For more details, refer to Section H of the Pharmaceutical
PRESCRIBER	PATIENT:
Name:	Name:

Ward: ...... NHI: ......

### Adalimumab (Amgevita) - continued

# **INITIATION – Plaque psoriasis - severe chronic** Re-assessment required after 4 months **Prerequisites** (tick boxes where appropriate) O Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ

	(	С	Patient has had an initial Special Authority approval for etanercept for severe chronic plaque psoriasis				
	and	or	<ul> <li>Patient has experienced intolerable side effects</li> <li>Patient has received insufficient benefit to meet the renewal criteria for etanercept for severe chronic plaque psoriasis</li> </ul>				
or							
		or	<ul> <li>Patient has "whole body" severe chronic plaque psoriasis with a (PASI) score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis</li> <li>Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis</li> <li>Patient has severe chronic localised genital or flexural plaque psoriasis where the plaques or lesions have been present for at least 6 months from the time of initial diagnosis, and with a Dermatology Life Quality Index (DLQI) score greater than 10</li> </ul>				
	and ( and	С С	Patient has tried, but had an inadequate response to, or has experienced intolerable side effects from, at least three of the following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, ciclosporin, or acitretin A PASI assessment or (DLQI) assessment has been completed for at least the most recent prior treatment course but no longer than 1 month following cessation of each prior treatment course and is no more than 1 month old at the time of application				

I confirm that the above details are correct	t:
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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:			
Adalimumab (Amgevita) - continued				
CONTINUATION – Plaque psoriasis - severe chronic Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)				

	and	or	<ul> <li>O The patient has experienced a 75% or more reduction in PASI score, or is sustained at this level, when compared with the pre-treatment baseline value</li> <li>O The patient has a DLQI improvement of 5 or more, when compared with the pre-treatment baseline value</li> </ul>
or			
O Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment and		Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment	
		or	<ul> <li>O The patient has experienced a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the treatment course baseline values</li> <li>O The patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline value</li> </ul>
or		$\overline{)}$	Detient had covere obvious locational conital or flavoural plague populacia at the start of tractment
	and		Patient had severe chronic localised genital or flexural plaque psoriasis at the start of treatment
		or	O The patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline value
			O Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing adalimumab

INITIATION – pyoderma gangrenosum								
Prerequisites (tick boxes where appropriate)								
O Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.								
Patient has pyoderma gangrenosum* Patient has received three months of conventional therapy including a minimum of three pharmaceuticals (e.g. prednisone, ciclosporin, azathioprine, or methotrexate) and not received an adequate response								
Note: Indications marked with * are unapproved indications.								

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.

PRESC	RIBE	R PATIENT:
Name:		Name:
Ward:		NHI:
Adalir	num	ab (Amgevita) - continued
Re-ass	sessm quisite	- Crohn's disease - adults ent required after 6 months es (tick boxes where appropriate)
and		escribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health Hospital.
é	ر _ and	Patient has severe active Crohn's disease
		O Patient has a CDAI score of greater than or equal to 300 or HBI score of greater than or equal to 10
		O Patient has extensive small intestine disease affecting more than 50 cm of the small intestine
		O Patient has evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel resection or
		O Patient has an ileostomy or colostomy and has intestinal inflammation
	and	Patient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators and corticosteroids
	<b>quisite</b>	ent required after 2 years es (tick boxes where appropriate) escribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health Hospital.
and	or	CDAI score has reduced by 100 points from the CDAI score, or HBI score has reduced 3 points, from when the patient was initiated on adalimumab
	or Or	CDAI score is 150 or less, or HBI is 4 or less
	С	The patient has demonstrated an adequate response to treatment, but CDAI score and/or HBI score cannot be assessed
Re-ass	sessm quisite ) Pre	- Crohn's disease - children ent required after 6 months es (tick boxes where appropriate) escribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health Hospital.
	and	Paediatric patient has active Crohn's disease
		O Patient has a PCDAI score of greater than or equal to 30 O Patient has extensive small intestine disease
	and	Patient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators and corticosteroids

RES	CRIBE	3	PATIENT:
			NUI.
		ab (Amgevita) - continued ION – Crohn's disease - children	
Re-a	ssessme	ent required after 2 years s (tick boxes where appropriate)	
( and		scribed by, or recommended by any relevant practitic Hospital.	oner, or in accordance with a protocol or guideline that has been endorsed by the Health
	or C	PCDAI score has reduced by 10 points from the P	CDAI score when the patient was initiated on adalimumab
	or	PCDAI score is 15 or less	
	C	The patient has demonstrated an adequate respon	nse to treatment but PCDAI score cannot be assessed
and	NZ	<ul> <li>Hospital.</li> <li>Patient has confirmed Crohn's disease</li> <li>O Patient has one or more complex externally</li> <li>O Patient has one or more rectovaginal fistula(</li> <li>O Patient has complex peri-anal fistula</li> </ul>	
Re-a	ssessme equisite O Pre	Hospital. The number of open draining fistulae have decrea	oner, or in accordance with a protocol or guideline that has been endorsed by the Health sed from baseline by at least 50% i all fistula(e) from baseline as demonstrated by a reduction in the Fistula Assessment

### I confirm that the above details are correct:

or

or

### 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.

PRES	SCRIE	BER			PATIENT:	
Name	ə:				Name:	
Ward	:				NHI:	
Adal	limu	mab	(An	nge	ngevita) - continued	
					r <b>inflammation - chronic</b> ired after 4 months	
Prer	equis	sites (	tick b	oxe	oxes where appropriate)	
and		Presc NZ Ho			by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that ha I.	s been endorsed by the Health
and	or	0	The p	oatie	patient has had an initial Special Authority approval for infliximab for chronic ocular inflammation	
		and	0		Patient has severe uveitis uncontrolled with treatment of steroids and other immunosuppressants wit loss	h a severe risk of vision
			or	С	O Patient is 18 years or older and treatment with at least two other immunomodulatory agents ha	s proven ineffective
			or	С	O Patient is under 18 years and treatment with methotrexate has proven ineffective or is not toler	ated at a therapeutic dose
				C	O Patient is under 8 years and treatment with steroids or methotrexate has proven ineffective or therapeutic dose; or disease requires control to prevent irreversible vision loss prior to achievin methotrexate	
Re-a	CONTINUATION – Ocular inflammation - chronic Re-assessment required after 2 years Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health					
and		NZ Ho				
	O The patient has had a good clinical response following 12 weeks' initial treatment					

Following each 2 year treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema)

Following each 2 year treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old

I confirm that the above details are correct:

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:	
Adal	limu	ımab	(Ai	ng	evi	ita) - continued	
<b>INITIATION – Ocular</b> Re-assessment requ <b>Prerequisites</b> (tick b					d af	fter 4 months	
( and	0	Presc NZ Ho			or	recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health	
	or	0	Patie	ent	nas	had an initial Special Authority approval for infliximab for severe ocular inflammation	
		and	O L	Pa	atie	nt has severe, vision-threatening ocular inflammation requiring rapid control	
			or or		$\mathbf{c}$	Treatment with high-dose steroids (intravenous methylprednisolone) followed by high dose oral steroids has proven ineffective at controlling symptoms Patient developed new inflammatory symptoms while receiving high dose steroids	
				OI	(	)	Patient is aged under 8 years and treatment with high dose oral steroids and other immunosuppressants has proven ineffective at controlling symptoms
Re-a	CONTINUATION – Ocular inflammation - severe Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)						
O Prescribed NZ Hospit					or	recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health	
	or	Ο	The	pat	ent	t has had a good clinical response following 3 initial doses	
	or		Nom	end	latu	each 2 year treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis ure (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of oid macular oedema)	

Following each 2 year treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old

I confirm that the above details are correct:

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Use this checklist to determine if a patient meets the restrictions for funding in the <b>hospital setting</b> .	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:
Adalimumab (Amgevita) - continued	
	nce with a protocol or guideline that has been endorsed by the Health NZ
Hospital. and O Patient has had an initial Special Authority approval for and O The patient has experienced intolerable side effect or O The patient has received insufficient benefit to me	ts
or Patient has a confirmed diagnosis of ankylosing spondy and Patient has low back pain and stiffness that is relieved by and Patient has bilateral sacroiliitis demonstrated by radiolog and Patient has not responded adequately to treatment with a regular exercise regimen for ankylosing spondylitis and	by exercise but not by rest
BASMI measures: a modified Schober's test of let than or equal to 10 cm (mean of left and right) O Patient has limitation of chest expansion by at lea gender and O A BASDAI of at least 6 on a 0-10 scale completed after	e in the sagittal and the frontal planes as determined by the following iss than or equal to 4 cm and lumbar side flexion measurement of less st 2.5 cm below the average normal values corrected for age and er the 3 month exercise trial, but prior to ceasing any previous a old at the time of application
CONTINUATION – ankylosing spondylitis         Re-assessment required after 2 years         Prerequisites (tick box where appropriate)         O       Prescribed by or recommended by any relevant practitioner, or in any second s	coordance with a protocol or quideline that has been endorsed by the Health

Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

For applications where treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10 point scale, or an improvement in BASDAI of 50%, whichever is less

and

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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.

PRES	SCRIE	BER	PATIENT:
Name	ə:		Name:
Ward	:		NHI:
Ada	limu	mab	(Amgevita) - continued
INIT Re-a	IATIO assess requis	<b>)N – A</b> sment <b>sites</b> ( Presc	<ul> <li>The patient has experienced intolerable side effects</li> <li>Patient has received insufficient benefit to meet the renewal criteria for oligoarticular course JIA</li> <li>To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance</li> <li>Patient has had oligoarticular course JIA for 6 months duration or longer</li> </ul>
Re-a	assess requis	sment <b>sites</b> ( Presci	N – Arthritis - oligoarticular course juvenile idiopathic required after 2 years (tick boxes where appropriate) ribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
and	or	0	Following initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baseline On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline

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.

PRES	SCRIE	BER		PATIENT:	
Name	ə:			Name:	
Ward	:			NHI:	
Ada	limu	mab	(An	gevita) - continued	
Re-a	issess	sment	requ	s - polyarticular course juvenile idiopathic red after 6 months exes where appropriate)	
and				by, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed h NZ Hospital.	
		and	O	<ul> <li>Patient has had an initial Special Authority approval for etanercept for polyarticular course juvenile idiopathic arthritis (JIA)</li> <li>Patient has experienced intolerable side effects</li> <li>Patient has received insufficient benefit to meet the renewal criteria for polyarticular course JIA</li> </ul>	
	or	and	Ο	To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance Patient has had polyarticular course JIA for 6 months duration or longer	
			or or	<ul> <li>At least 5 active joints and at least 3 joints with limited range of motion, pain or tenderness after a 3-month trial of methotrexate (at the maximum tolerated dose)</li> <li>Moderate or high disease activity (cJADAS10 score of at least 2.5) after a 3-month trial of methotrexate (at the maximum tolerated dose)</li> <li>Low disease activity (cJADAS10 score between 1.1 and 2.5) after a 6-month trial of methotrexate</li> </ul>	
Re-a	CONTINUATION – Arthritis - polyarticular course juvenile idiopathic Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)				
(		Presci NZ Ho		by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health	

O Following initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baseline

On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline

and

or

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.	

PRES	SCRIB	ER		PATIENT:
Name	ame: Name:			
Ward	:			NHI:
Adal	limur	nab	(An	ngevita) - continued
Re-a	assess <b>equis</b> O F	ment r <b>ites</b> (ti	requi ck b bed	is - psoriatic ired after 6 months oxes where appropriate) by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
		( and	C	Patient has had an initial Special Authority approval for etanercept or secukinumab for psoriatic arthritis
			or	<ul> <li>O Patient has experienced intolerable side effects</li> <li>O Patient has received insufficient benefit to meet the renewal criteria for psoriatic arthritis</li> </ul>
	or	( and ( and ( and	С С С	Patient has had active psoriatic arthritis for six months duration or longer Patient has tried and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated) Patient has tried and not responded to at least three months of sulfasalazine or leflunomide at maximum tolerated doses (unless contraindicated)
			or	<ul> <li>Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen joints</li> <li>Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip</li> </ul>
		and	or or	<ul> <li>Patient has CRP level greater than 15 mg/L measured no more than one month prior to the date of this application</li> <li>Patient has an elevated ESR greater than 25 mm per hour</li> <li>ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months</li> </ul>
Re-a	assess requis	ment r <b>ites</b> (ti	equi ck b bed	rthritis - psoriatic ired after 2 years oxes where appropriate) by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health I.
	or (	re F	espo Patier	wing initial treatment, the patient has at least a 50% decrease in swollen joint count from baseline and a clinically significant onse in the opinion of the physician nt demonstrates at least a continuing 30% improvement in swollen joint count from baseline and a clinically significant response opinion of the treating physician

Use this checklist to determine if a patient meets the restrictions for funding in the hospital setting. For	or more details, refer to Section H of the Pharmaceutical
Schedule. For community funding, see the Special Authority Criteria.	

PRESCRI	BER		PATIENT:
Name:			Name:
Ward:			NHI:
Adalimu	ımab	(An	ngevita) - continued
Re-asses	ssment <b>sites</b> (t	requ ick b ibed	is - rheumatoid ired after 6 months oxes where appropriate) by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
	and	or	The patient has had an initial Special Authority approval for etanercept for rheumatoid arthritis         O       The patient has experienced intolerable side effects         O       The patient has received insufficient benefit from etanercept to meet the renewal criteria for rheumatoid arthritis
or	and and and	0 0 0	Patient has had rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic citrullinated peptide (CCP) antibody positive) for six months duration or longer Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance Patient has tried and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated) Patient has tried and not responded to at least three months of methotrexate in combination with sulfasalazine and hydroxychloroquine sulphate at maximum tolerated doses (unless contraindicated)
	and	or	<ul> <li>Patient has tried and not responded to at least three months of methotrexate in combination with the maximum tolerated dose of ciclosporin</li> <li>Patient has tried and not responded to at least three months of therapy at the maximum tolerated dose of leflunomide alone or in combination with methotrexate</li> <li>Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen joints</li> </ul>
Re-asses	sment	requ	Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip  rthritis - rheumatoid ired after 2 years oxes where appropriate)
	SILES (I		aves milele appropriate)

( and	O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the NZ Hospital.		
	or	0	Following initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician
	U	0	On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician

I confirm that the above details are correct:

Signed: [	Date:
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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.

PRES	CRIB	ER PATIENT:
Name	:	Name:
Ward:		NHI:
Adali	imur	nab (Amgevita) - continued
	equisi	N – Still's disease - adult-onset (AOSD) ites (tick boxes where appropriate)
and		Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
		O The patient has had an initial Special Authority approval for etanercept and/or tocilizumab for (AOSD)
		O Patient has experienced intolerable side effects from etanercept and/or tocilizumab
		O Patient has received insufficient benefit from at least a three-month trial of etanercept and/or tocilizumab
	or	
		O Patient diagnosed with AOSD according to the Yamaguchi criteria and
		O Patient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, NSAIDs and methotrexate
		O Patient has persistent symptoms of disabling poorly controlled and active disease
Prere	equisi	ment required after 6 months ites (tick boxes where appropriate) Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health IZ Hospital.
and	( and	O Patient has active ulcerative colitis
		O Patient's SCCAI score is greater than or equal to 4
		O Patient's PUCAI score is greater than or equal to 20
	and (	Patient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators and systemic corticosteroids
	(	O Surgery (or further surgery) is considered to be clinically inappropriate
	TINU	ATION – ulcerative colitis
		ment required after 2 years i <b>tes</b> (tick boxes where appropriate)
and		Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health IZ Hospital.
	( or	The SCCAI score has reduced by 2 points or more from the SCCAI score when the patient was initiated on biologic therapy
	. (	O The PUCAI score has reduced by 10 points or more from the PUCAI score when the patient was initiated on biologic therapy

Forn July 2	n RS2 025	2063		HOSPITAL MEDICINES LIST Page 39 RESTRICTIONS CHECKLIST		
			determine if a patient meets the restrictions for funding in a unity funding, see the Special Authority Criteria.	the <b>hospital setting</b> . For more details, refer to Section H of the Pharmace	eutical	
PRES	CRIBE	R		PATIENT:		
Name	:			Name:		
Ward:				NHI:		
Adal	imum	nab (A	mgevita) - continued			
Re-a	ssessm	nent requ	ferentiated spondyloarthiritis uired after 6 months boxes where appropriate)			
and	) Pr			nce with a protocol or guideline that has been endorsed by the Health NZ	<u>-</u>	
	and		ent has undifferentiated peripheral spondyloarthritis* with t, elbow, knee, ankle, and either shoulder or hip	active peripheral joint arthritis in at least four joints from the following:		
	and		ent has tried and not responded to at least three months rated doses (unless contraindicated)	of each of methotrexate, sulphasalazine and leflunomide, at maximum		
		or O		d no more than one month prior to the date of this application		
		or O	ESR and CRP not measured as patient is currently rec	sured no more than one month prior to the date of this application eiving prednisone therapy at a dose of greater than 5 mg per day and		
			has done so for more than three months arked with * are unapproved indications.			
Re-a	ssessm equisit O Pr	nent requ i <b>es</b> (tick		ccordance with a protocol or guideline that has been endorsed by the He	ealth	
	or		owing initial treatment, the patient has at least a 50% dec ionse to treatment in the opinion of the physician	rease in active joint count from baseline and a clinically significant		
			patient demonstrates at least a continuing 30% improver onse in the opinion of the treating physician	nent in active joint count from baseline and a clinically significant		
Re-a	ssessm equisit O Pr	nent requ es (tick rescribed ospital.	nmatory bowel arthritis – axial uired after 6 months boxes where appropriate) d by, or recommended by a rheumatologist, or in accorda ent has a diagnosis of active ulcerative colitis or active C	nce with a protocol or guideline that has been endorsed by the Health NZ rohn's disease	<u>z</u>	
	and and	) Patie	ent has axial inflammatory pain for six months or more			
	and	) Patie	ent is unable to take NSAIDs			
	C	) Patie	ent has unequivocal sacroiliitis demonstrated by radiolog	cal imaging or MRI		
	and		ent has not responded adequately to prior treatment cons siotherapist	sisting of at least 3 months of an exercise regime supervised by a		
	and		ASDAI of at least 6 on a 0-10 scale completed after the 3 tment	month exercise trial, but prior to ceasing any previous pharmacological		

Use this checklist to determine if a patient meets the restrictions for funding in the <b>hospital setting</b> . 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:			
Adalimumab (Amgevita) - continued				
CONTINUATION – inflammatory bowel arthritis – axial Re-assessment required after 2 years				
Prerequisites (tick box where appropriate)				
O Prescribed by, or recommended by any relevant practitioner, or in NZ Hospital.	accordance with a protocol or guideline that has been endorsed by the Health			
	or more points from pre-treatment baseline on a 10 point scale, or an			
INITIATION – inflammatory bowel arthritis – peripheral Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)				
	lance with a protocol or guideline that has been endorsed by the Health NZ			
Patient has a diagnosis of active ulcerative colitis or active ( and				
and Patient has active arthritis in at least four joints from the foll	owing: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder,			
O Patient has tried and not experienced a response to at lease dose (unless contraindicated)	t three months of methotrexate, or azathioprine at a maximum tolerated			
and Patient has tried and not experienced a response to at lease contraindicated) and	t three months of sulphasalazine at a maximum tolerated dose (unless			
O Patient has a CRP level greater than 15 mg/L measur	red no more than one month prior to the date of this application			
O Patient has an ESR greater than 25 mm per hour				
	eceiving prednisone therapy at a dose of greater than 5 mg per day and			
CONTINUATION – inflammatory bowel arthritis – peripheral Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)				
NZ Hospital.	accordance with a protocol or guideline that has been endorsed by the Health			
and O Following initial treatment, the patient has at least a 50% de response to treatment in the opinion of the physician or	ecrease in active joint count from baseline and a clinically significant			

O Patient demonstrates at least a continuing 30% improvement in active joint count from baseline in the opinion of the treating physician

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:		

# Palivizumab

( and	F C	Paliviz	umab	o to be administered during the annual RSV season
		and	$\overline{\mathbf{O}}$	Infant was born in the last 12 months Infant was born at less than 32 weeks zero days' gestation
	or	and	O	Child was born in the last 24 months
			or	O Child has severe lung, airway, neurological or neuromuscular disease that requires ongoing ventilatory/respiratory support (see Note A) in the community
				and C Child has haemodynamically significant heart disease and C Child has unoperated simple congenital heart disease with significant left to right shunt (see Note B) or O Child has unoperated or surgically palliated complex congenital heart disease or
				O Child has severe pulmonary hypertension (see Note C) or O Child has moderate or severe left ventricular (LV) failure (see Note D)
			or	O Child has severe combined immune deficiency, confirmed by an immunologist, but has not received a stem cell

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.

PRESCRIB	ER		PATIENT:
Name:			Name:
Ward:			NHI:
Palivizun	nab	- contii	nued
CONTINUA Re-assess	ATION iment ites (t	N require tick bo> Palivizu Child w	ed after 6 months xes where appropriate) umab to be administered during the annual RSV season vas born in the last 24 months Child has severe lung, airway, neurological or neuromuscular disease that requires ongoing ventilatory/respiratory support (see Note A) in the community O Child has haemodynamically significant heart disease or O Child has unoperated simple congenital heart disease with significant left to right shunt (see Note B) or O Child has unoperated or surgically palliated complex congenital heart disease
	or or	Oc	O Child has severe pulmonary hypertension (see Note C) or O Child has moderate or severe left ventricular (LV) failure (see Note D) Child has severe combined immune deficiency, confirmed by an immunologist, but has not received a stem cell transplant Child has inborn errors of immunity (see Note E) that increase susceptibility to life-threatening viral respiratory infections, confirmed by an immunologist

#### Note:

- a) Ventilatory/respiratory support includes those on home oxygen, CPAP/VPAP and those with tracheostomies in situ managed at home
- b) Child requires/will require heart failure medication, and/or child has significant pulmonary hypertension, and/or infant will require surgical palliation/definitive repair within the next 3 months
- c) Mean pulmonary artery pressure more than 25 mmHg
- d) LV Ejection Fraction less than 40%
- e) Inborn errors of immunity include, but are not limited to, IFNAR deficiencies

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:

# Gemtuzumab ozogamicin

#### INITIATION Prerequisites (tick boxes where appropriate) () Patient has not received prior chemotherapy for this condition and Patient has de novo CD33-positive acute myeloid leukaemia and Patient does not have acute promyelocytic leukaemia and Gemtuzumab ozogamicin will be used in combination with standard anthracycline and cytarabine (AraC) and Patient is being treated with curative intent and Patient's disease risk has been assessed by cytogenetic testing to be good or intermediate and Patient must be considered eligible for standard intensive remission induction chemotherapy with standard anthracycline and cytarabine (AraC) and Gemtuzumab ozogamicin to be funded for one course only (one dose at 3 mg per m<sup>2</sup> body surface area or up to 2 vials of 5 mg as separate doses)

Note: Acute myeloid leukaemia excludes acute promyelocytic leukaemia and acute myeloid leukaemia that is secondary to another haematological disorder (eg myelodysplasia or myeloproliferative disorder).

SCRIBE	ER		PATIENT:
ie:			Name:
d:			NHI:
ralizu	ma	ıb	
		Severe eosinophilic asthma	
		t required after 12 months (tick boxes where appropriate)	
requisit	les	(lick boxes where appropriate)	
		ribed by, or recommended by a respiratory physician or clin rsed by the Health NZ Hospital.	ical immunologist, or in accordance with a protocol or guideline that has been
and	)	Patient must be aged 12 years or older	
and	)	Patient must have a diagnosis of severe eosinophilic asthm	a documented by a respiratory physician or clinical immunologist
and	)		central airway obstruction, bronchiolitis etc. have been excluded
and		Patient has a blood eosinophil count of greater than $0.5 \times 1$	0 <sup>9</sup> cells/L in the last 12 months
	ر		uding inhaled corticosteroids (equivalent to at least 1000 mcg per day of budesonide/formoterol as part of the anti-inflammatory reliever therapy plus ed
and	or	defined as either documented use of oral corticoster	temic corticosteroids in the previous 12 months, where an exacerbation is bids for at least 3 days or parenteral corticosteroids of at least the equivalent of 10 mg per day over the previous 3 months
and	)	Treatment is not to be used in combination with subsidised	mepolizumab
and	C	Patient has an Asthma Control Test (ACT) score of 10 or le and oral corticosteroid dose must be made at the time of an response to treatment	ss. Baseline measurements of the patient's asthma control using the ACT oplication, and again at around 52 weeks after the first dose to assess
	or	O Patient has not previously received an anti-IL5 biolog	ical therapy for their severe eosinophilic asthma
			anti-IL5 biological therapy vith previous anti-IL5 biological therapy and discontinued within
		12 months of commencing treatment	
assessn	nen	N – Severe eosinophilic asthma t required after 2 years	
requisit	es	(tick boxes where appropriate)	
() D.	resc	ribed by, or recommended by a respiratory physician or clin	ical immunologist, or in accordance with a protocol or guideline that has bee

 $O\,$  Exacerbations have been reduced from baseline by 50% as a result of treatment with benralizumab

O Reduction in continuous oral corticosteroid use by 50% or by 10 mg/day while maintaining or improving asthma control

and

or

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:		

# Ustekinumab

INITIATION – Crohn's disease - adults         Re-assessment required after 6 months         Prerequisites (tick boxes where appropriate)
Patient is currently on treatment with ustekinumab commenced prior to 1 February 2023 and met all remaining criteria (criterion 2) below at the time of commencing treatment
O Patient has active Crohn's disease
O Patient has had an initial approval for prior biologic therapy for Crohn's disease and has experienced intolerable side effects or insufficient benefit to meet renewal criteria
O Patient meets the initiation criteria for prior biologic therapies for Crohn's disease and O Other biologics for Crohn's disease are contraindicated
CONTINUATION – Crohn's disease - adults Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)
CDAI score has reduced by 100 points, or HBI score has reduced by 3 points, from when the patient was initiated on biologic therapy or
CDAI score is 150 or less, or HBI is 4 or less
or O The patient has experienced an adequate response to treatment, but CDAI score and/or HBI score cannot be assessed
and Ustekinumab to be administered at a dose no greater than 90 mg every 8 weeks
INITIATION – Crohn's disease - children* Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)
O Patient is currently on treatment with ustekinumab commenced prior to 1 February 2023 and met all remaining criteria (criterion 2) below at the time of commencing treatment
O Patient has active Crohn's disease
O Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria
Patient meets the initiation criteria for prior biologic therapies for Crohn's disease and Other biologics for Crohn's disease are contraindicated
Note: Indication marked with * is an unapproved indication.

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:			
Ustekinumab - continued				
CONTINUATION – Crohn's disease - children* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)				
O PCDAI score has reduced by 10 points from when or O PCDAI score is 15 or less or O The patient has experienced an adequate response	the patient was initiated on biologic therapy se to treatment, but CDAI score cannot be assessed			
and O Ustekinumab to administered at a dose no greater than the second s	90 mg every 8 weeks			
Note: Indication marked with * is an unapproved indication.				
or below at the time of commencing treatment O Patient has active ulcerative colitis and O Patient has had an initial approval for prior b effects or insufficient benefit to meet renewa	nenced prior to 1 February 2023 and met all remaining criteria (criterion 2) piologic therapy for ulcerative colitis and has experienced intolerable side al criteria prior biologic therapies for ulcerative colitis			
O Other biologics for ulcerative colitis are	e contraindicated			
CONTINUATION – ulcerative colitis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)				
or	e from the SCCAI score since initiation on biologic therapy om the PUCAI score since initiation on biologic therapy*			
and Ustekinumab will be used at a dose no greater than 90 r	ng intravenously every 8 weeks			

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:		

# Vedolizumab

INITIATION – Crohn's disease - adults Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)						
	O Patient has active Crohn's disease					
			0	Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria (unless contraindicated)		
		or or	0	Patient has a CDAI score of greater than or equal to 300, or HBI score of greater than or equal to 10		
		or	Ο	Patient has extensive small intestine disease affecting more than 50 cm of the small intestine		
		or	0	Patient has evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel resection		
	and		0	Patient has an ileostomy or colostomy, and has intestinal inflammation		
	and		0	Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response) from prior therapy with immunomodulators and corticosteroids		
		or or	Ο	Patient has experienced intolerable side effects from immunomodulators and corticosteroids		
			Ο	Immunomodulators and corticosteroids are contraindicated		
Re-as	CONTINUATION – Crohn's disease - adults Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)					
			0	CDAI score has reduced by 100 points, or HBI score has reduced by 3 points, from when the patient was initiated on biologic therapy		
		or or	Ο	CDAI score is 150 or less, or HBI is 4 or less		
			Ο	The patient has experienced an adequate response to treatment, but CDAI score and/or HBI score cannot be assessed		
	and	_				

Vedolizumab to administered at a dose no greater than 300 mg every 8 weeks

 $\bigcirc$ 

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:			
Vedolizumab - continued				

Re-a	ssess	men	Crohn's disease - children* t required after 6 months (tick boxes where appropriate)
	Paediatric patient has active Crohn's disease		Paediatric patient has active Crohn's disease
			O Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria (unless contraindicated)
		or	O Patient has a Paediatric Crohn's Disease Activity Index (PCDAI) score of greater than or equal to 30
	or O Patient has extensive small intestine disease		
	and O Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial respo		O Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response)
or O Petiant has superiors and intelevable side affects from immunemedulators and certicesteroids		from prior therapy with immunomodulators and corticosteroids O Patient has experienced intolerable side effects from immunomodulators and corticosteroids	
		or	O Immunomodulators and corticosteroids are contraindicated
Note	: India	catio	n marked with * is an unapproved indication.
Re-a	ssess	men	DN – Crohn's disease - children* t required after 2 years (tick boxes where appropriate)
			O PCDAI score has reduced by 10 points from when the patient was initiated on biologic therapy
		or or	O PCDAI score is 15 or less
			O The patient has experienced an adequate response to treatment, but CDAI score cannot be assessed

 $m O\,$  Vedolizumab to administered at a dose no greater than 300mg every 8 weeks

Note: Indication marked with \* is an unapproved indication.

and

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:

# Vedolizumab - continued

INITIATION – ulcerative colitis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)				
·	Patient has active ulcerative colitis			
			O Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria (unless contraindicated)	
		or	O Patient has a SCCAI score is greater than or equal to 4	
			O Patient's PUCAI score is greater than or equal to 20*	
a	and O Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response) from prior therapy with immunomodulators and corticosteroids			
		or	O Patient has experienced intolerable side effects from immunomodulators and corticosteroids	
			O Immunomodulators and corticosteroids are contraindicated	
Note: Indication marked with * is an unapproved indication.				
Re-asse	essr	men	N – ulcerative colitis t required after 2 years (tick boxes where appropriate)	
	or O The SCCAI score has reduced by 2 points or more from the SCCAI score since initiation on biologic therapy O The PUCAI score has reduced by 10 points or more from the PUCAI score since initiation on biologic therapy *		O The SCCAI score has reduced by 2 points or more from the SCCAI score since initiation on biologic therapy	
			O The PUCAI score has reduced by 10 points or more from the PUCAI score since initiation on biologic therapy *	
a	nd (	С	Vedolizumab will be used at a dose no greater than 300 mg intravenously every 8 weeks	

Note: Indication marked with \* is an unapproved indication.

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:

# Brentuximab

Re-assessmer	relapsed/refractory Hodgkin lymphoma nt required after 6 months (tick boxes where appropriate)	
	O Patient has relapsed/refractory CD30-positive Hodgkin lymphoma after two or more lines of chemotherapy and O Patient is ineligible for autologous stem cell transplant	
or	O Patient has relapsed/refractory CD30-positive Hodgkin lymphoma and O Patient has previously undergone autologous stem cell transplant	
and and and and	Patient has not previously received funded brentuximab vedotin Response to brentuximab vedotin treatment is to be reviewed after a maximum of 6 treatment cycles Brentuximab vedotin to be administered at doses no greater than 1.8 mg/kg every 3 weeks	
Re-assessmer	DN – relapsed/refractory Hodgkin lymphoma ht required after 9 months (tick boxes where appropriate)	
and and	O Treatment remains clinically appropriate and the patient is benefitting from treatment and treatment is being tolerated	
Re-assessmer	anaplastic large cell lymphoma ht required after 9 months (tick boxes where appropriate)	
and and	Patient has relapsed/refractory CD30-positive systemic anaplastic large cell lymphoma Patient has an ECOG performance status of 0-1	

Patient has not previously received brentuximab vedotin

Response to brentuximab vedotin treatment is to be reviewed after a maximum of 6 treatment cycles

Brentuximab vedotin to be administered at doses no greater than 1.8 mg/kg every 3 weeks

)

and

and

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.

PRE	SCRIBER		PATIENT:	
Name	ə:		Name:	
Ward	:		NHI:	
Brer	ntuxima	<b>b</b> - continued		
CONTINUATION – anaplastic large cell lymphoma Re-assessment required after 9 months				
Prer	equisites	(tick boxes where appropriate)		
	O Patient has achieved a partial or complete response to brentuximab vedotin after 6 treatment cycles		ximab vedotin after 6 treatment cycles	
and Treatment remains clinically appropriate and the patient is benefitting from treatment and treatment is being tolerated and Patient is to receive a maximum of 16 total cycles of brentuximab vedotin treatment			efitting from treatment and treatment is being tolerated	
			nab vedotin treatment	

Form RS2005 July 2025	HOSPITAL MEDICINES LIST Page 4 RESTRICTIONS CHECKLIST
	e if a patient meets the restrictions for funding in the <b>hospital setting</b> . For more details, refer to Section H of the Pharmaceutical ding, see the Special Authority Criteria.
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Trastuzumab (Herzum	a)
INITIATION – early breast of Re-assessment required afte Prerequisites (tick boxes w	er 12 months here appropriate)
and	has early breast cancer expressing HER-2 IHC 3+ or ISH + (including FISH or other current technology imulative dose of 106 mg/kg (12 months' treatment)
and O The pa	er 12 months
or O	The patient has not previously received lapatinib treatment for HER-2 positive metastatic breast cancer The patient discontinued lapatinib within 3 months due to intolerable side effects and the cancer did not progress whilst on lapatinib He cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab
and or and and	O Patient has not received prior treatment for their metastatic disease and has had a treatment-free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer
or O Patien	zumab to be discontinued at disease progression t has previously discontinued treatment with trastuzumab in the metastatic setting for reasons other than severe toxicity hase progression

O Disease has not progressed during previous treatment with trastuzumab

O Patient has signs of disease progression

Note: \* For patients with relapsed HER-2 positive disease who have previously received adjuvant trastuzumab for early breast cancer

and

and

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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:
<b>_</b>	

# Trastuzumab (Herzuma) - continued

( and	$\mathbf{C}$	The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)
ſ		O The patient has not previously received lapatinib treatment for HER-2 positive metastatic breast cancer
	or	O The patient discontinued lapatinib within 3 months due to intolerable side effects and the cancer did not progress whilst on lapatinib
and		2
	or	O Trastuzumab will not be given in combination with pertuzumab
		<ul> <li>Trastuzumab to be administered in combination with pertuzumab</li> <li>Patient has not received prior treatment for their metastatic disease and has had a treatment-free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer</li> <li>The patient has good performance status (ECOG grade 0-1)</li> </ul>
and	C	Trastuzumab to be discontinued at disease progression
	<b>TIO</b>	N – metastatic breast cancer

	U. O	The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)
	and O and	The cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab
		Trastuzumab to be discontinued at disease progression
or		
	and	Patient has previously discontinued treatment with trastuzumab for reasons other than severe toxicity or disease progression
	Ο	Patient has signs of disease progression
	and	Disease has not progressed during previous treatment with trastuzumab

#### INITIATION – gastric, gastro-oesophageal junction and oesophageal cancer Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)

riciequisites (lick boxes where appropriate,

 $\bigcirc$ 

and

The patient has locally advanced or metastatic gastric, gastro-oesophageal junction or oesophageal cancer expressing HER-2 IHC 2+ FISH+ or IHC3+ (or other current technology)

O Patient has an ECOG score of 0-2

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:		Name:	
Ward:		NHI:	
Trastuzumab (Herzuma) - continued			
CONTINUATION – gastric, gastro-oesophageal junction and oesophageal cancer Re-assessment required after 12 months			
Prerequisites (tick boxes where appropriate)			
O The cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab			
O Trastuzumab to be discontinued at disease progression			

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:

# Trastuzumab deruxtecan

Re-a		smer	t required after 6 months (tick boxes where appropriate)
	and	0	Patient has metastatic breast cancer expressing HER-2 IHC3+ or ISH+ (including FISH or other current technology)
	and and	0	Patient has previously received trastuzumab and chemotherapy, separately or in combination
		or	O The patient has received prior therapy for metastatic disease
			O The patient developed disease recurrence during, or within six months of completing adjuvant therapy
	and and	0	Patient has a good performance status (ECOG 0-1)
	and	Ο	Patient has not received prior funded trastuzumab deruxtecan treatment
		Ο	Treatment to be discontinued at disease progression
Re-a		smer	ON It required after 6 months (tick boxes where appropriate)
	and	0	The cancer has not progressed at any time point during the previous approval period whilst on trastuzumab deruxtecan

O Treatment to be discontinued at disease progression

Note: Prior or adjuvant therapy includes anthracycline, other chemotherapy, biological drugs, or endocrine therapy.

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:

# Bevacizumab

Re-assessment	<ul> <li>Patient has preserved liver function (Child-Pugh A)</li> <li>Transarterial chemoembolisation (TACE) is unsuitable</li> </ul>
and	O Patient has an ECOG performance status of 0-2
Re-assessment Prerequisites	VN – unresectable hepatocellular carcinoma t required after 6 months (tick box where appropriate) vidence of disease progression
Re-assessmen	advanced or metastatic ovarian cancer t required after 4 months (tick boxes where appropriate)

	O The patient has previously untreated advanced (FIGO Stage IIIB or IIIC) epithelial ovarian, fallopian tube, or primary
	peritoneal cancer
	O Debulking surgery is inappropriate
	or
	O The cancer is sub-optimally debulked (maximum diameter of any gross residual disease greater than 1cm)
and	
$\sim$	Bevacizumab to be administered at a maximum dose of 15 mg/kg every three weeks

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:
Bevacizumab - continued	
CONTINUATION – advanced or metastatic ovarian cancer Re-assessment required after 4 months	
Prerequisites (tick box where appropriate) O No evidence of disease progression	
INITIATION – Recurrent Respiratory Papillomatosis Re-assessment required after 12 months	
Prerequisites (tick boxes where appropriate)	
Maximum of 6 doses	
O The patient has recurrent respiratory papillomatosis and	
O The treatment is for intra-lesional administration	
CONTINUATION – Recurrent Respiratory Papillomatosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
Maximum of 6 doses	
The treatment is for intra-lesional administration	
O There has been a reduction in surgical treatments or disease	regrowth as a result of treatment
INITIATION – Ocular Conditions           Prerequisites (tick boxes where appropriate)	
O Ocular neovascularisation	
O Exudative ocular angiopathy	

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:

# Inotuzumab ozogamicin

or

and

# INITIATION

and	0	Patient has relapsed or refractory CD22-positive B-cell acute lymphoblastic leukaemia/lymphoma, including minimal residual disease
and	0	Patient has ECOG performance status of 0-2
		O Patient has Philadelphia chromosome positive B-Cell ALL
		and O Patient has previously received a tyrosine kinase inhibitor
	or	
		O Patient has received one prior line of treatment involving intensive chemotherapy
and	0	Treatment is to be administered for a maximum of 3 cycles
TINU	ATIO	Treatment is to be administered for a maximum of 3 cycles
TINU	<b>ATIO</b>	Treatment is to be administered for a maximum of 3 cycles

O Patient has experienced complete remission with incomplete haematological recovery

O Treatment with inotuzumab ozogamicin is to cease after a total duration of 6 cycles

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:
Basiliximab	
INITIATION	
Prerequisites (tick box where appropriate)	
${ m O}~$ For use in solid organ transplants	

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.

PRESC	RIB	ER		PATIENT:
Name:				Name:
Ward:				NHI:
Rituxi	mal	<b>o</b> (Mal	othe	ra)
Re-ass Prerec	sessr <b>quisi</b> t ) Pi	nent re <b>tes</b> (tio	equ ck b bed	atoid arthritis - prior TNF inhibitor use red after 4 months oxes where appropriate) by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and		and	or	The patient has had an initial community Special Authority approval for at least one of etanercept and/or adalimumab for rheumatoid arthritis O The patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept O Following at least a four month trial of adalimumab and/or etanercept, the patient did not meet the renewal criteria for adalimumab and/or etanercept for rheumatoid arthritis
á	and			
	and	or (	) )	Rituximab to be used as an adjunct to methotrexate or leflunomide therapy Patient is contraindicated to both methotrexate and leflunomide, requiring rituximab monotherapy to be used
		Ом	axir	num of two 1,000 mg infusions of rituximab given two weeks apart

Use this checklist to determine if a patient meets the restrictions for funding in the <b>hospital setting</b> . For more details, refer to Section H of the Pharmaceutica Schedule. For community funding, see the Special Authority Criteria.

	ER	R PATIENT:	
e:		Name:	
:		NHI:	
xima	<b>b</b> (N	(Mabthera) - continued	
		- rheumatoid arthritis - TNF inhibitors contraindicated	
		ent required after 4 months es (tick boxes where appropriate)	
		escribed by, or recommended by a rheumatologist, or in accordance with a protocol or gui	ideline that has been endersed by the Health N
		spital.	idenne that has been endorsed by the freath ha
( and	С	Treatment with a Tumour Necrosis Factor alpha inhibitor is contraindicated	
(	С	Patient has had severe and active erosive rheumatoid arthritis (either confirmed by rac citrullinated peptide (CCP) antibody positive) for six months duration or longer	diology imaging, or the patient is cyclic
and (	С	Patient has tried and not responded to at least three months of oral or parenteral mether maximum tolerated dose	notrexate at a dose of at least 20 mg weekly or a
and (		<ul><li>Patient has tried and not responded to at least three months of oral or parenteral meth</li></ul>	
and		hydroxychloroquine sulphate (at maximum tolerated doses)	
	or	O Patient has tried and not responded to at least three months of oral or parentera maximum tolerated dose of cyclosporin	al methotrexate in combination with the
		O Patient has tried and not responded to at least three months of oral or parentera gold	al methotrexate in combination with intramuscula
	or	O Patient has tried and not responded to at least three months of therapy at the m in combination with oral or parenteral methotrexate	aximum tolerated dose of leflunomide alone or
and	$\subset$		
	or	O Patient has persistent symptoms of poorly controlled and active disease in at lea	ast 20 swollen, tender joints
		O Patient has persistent symptoms of poorly controlled and active disease in at lea knee, ankle, and either shoulder or hip	ast four joints from the following: wrist, elbow,
and	$\subseteq$		
	or	O Patient has a C-reactive protein level greater than 15 mg/L measured no more that application	than one month prior to the date of this
		O C-reactive protein levels not measured as patient is currently receiving predniso day and has done so for more than three months	one therapy at a dose of greater than 5 mg per
and			
	or	O Rituximab to be used as an adjunct to methotrexate or leflunomide therapy	
		O Patient is contraindicated to both methotrexate and leflunomide, requiring rituxin	nab monotherapy to be used
and (	C	Maximum of two 1,000 mg infusions of rituximab given two weeks apart	

	BER			PATIENT:			
:				Name:			
				NHI:			
kima	ab (N	/labthe	era) - continued				
ssess	smen	it requ	heumatoid arthritis - re-treatment in 'partial responuired after 4 months boxes where appropriate)	Iders' to rituximab			
	Preso Hosp		by, or recommended by a rheumatologist, or in accord	ance with a protocol or guideline that has been endorsed by the Health NZ			
	or	0	At 4 months following the initial course of rituximab in count from baseline and a clinically significant respon	fusions the patient had between a 30% and 50% decrease in active joint use to treatment in the opinion of the physician			
	or	0	At 4 months following the second course of rituximab from baseline and a clinically significant response to t	o infusions the patient had at least a 50% decrease in active joint count treatment in the opinion of the physician			
		0		ses of rituximab infusions, the patient demonstrates at least a continuing and a clinically significant response to treatment in the opinion of the			
and A Rituximab re-treatment not to be given within 6 months of the previous course of treatment and O Rituximab to be used as an adjunct to methotrexate or leflunomide therapy							
							O Patient is contraindicated to both methotrexate and leflunomide, requiring rituximab monotherapy to be used
and	Ο	Махі	imum of two 1,000 mg infusions of rituximab given two	weeks apart			
ssess equis	smen sites	it requ (tick t cribed	heumatoid arthritis - re-treatment in 'responders' to uired after 4 months boxes where appropriate) by, or recommended by a rheumatologist, or in accord	o rituximab dance with a protocol or guideline that has been endorsed by the Health NZ			
ŀ		0	At 4 months following the initial course of rituximab in baseline and a clinically significant response to treatm	fusions the patient had at least a 50% decrease in active joint count from nent in the opinion of the physician			
ŀ	or			urses of rituximab infusions, the patient demonstrates at least a continuing and a clinically significant response to treatment in the opinion of the			
		0	physician				
and	0	Ritux		ne previous course of treatment			
and	0	Ritux	physician kimab re-treatment not to be given within 6 months of the Rituximab to be used as an adjunct to methotrexate o	·			

# RS1922 - Adalimumab (Humira - Alternative brand)

Arthritis - polyarticular course juvenile idiopathic - INITIATION	430
Arthritis - polyarticular course juvenile idiopathic - INTHATON	
Arthritis - psoriatic - INITIATION	
Arthritis - psoriatic - CONTINUATION	431
Arthritis – oligoarticular course juvenile idiopathic - INITIATION	429
Arthritis – oligoarticular course juvenile idiopathic - CONTINUATION	430
Arthritis – rheumatoid - INITIATION	
Arthritis – rheumatoid - CONTINUATION	
Behcet's disease - severe - INITIATION	
Behcet's disease - severe - CONTINUATION	
Crohn's disease - adult - INITIATION	
Crohn's disease - adult - CONTINUATION	
Crohn's disease - children - INITIATION	
Crohn's disease - children - CONTINUATION	
Crohn's disease - fistulising - INITIATION	
Crohn's disease - fistulising - CONTINUATION	
Hidradenitis suppurativa - INITIATION	
Hidradenitis suppurativa - CONTINUATION	
Ocular inflammation – chronic - INITIATION	
Ocular inflammation – chronic - CONTINUATION	
Ocular inflammation - severe - INITIATION	
Ocular inflammation – severe - CONTINUATION	
Psoriasis - severe chronic plaque - INITIATION	
Psoriasis - severe chronic plaque - CONTINUATION	
Pyoderma gangrenosum - INITIATION	
Pyoderma gangrenosum - CONTINUATION	
Still's disease - adult-onset (AOSD) - INITIATION	
Still's disease – adult-onset (AOSD) - CONTINUATION	
Ankylosing spondylitis - INITIATION	
Ankylosing spondylitis - CONTINUATION	

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:			
Adalimumab (Humira - Alternative brand)				
	practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health			
NZ Hospital.				
O Patient has developed symptoms of lo	ble side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment oss of disease control following a minimum of 4 weeks treatment with adalimumab s loss of disease response to a change in treatment regimen			
<ul> <li>and</li> <li>Patient has received a maximum of 6 months treatment with Amgevita</li> <li>and</li> <li>Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication</li> <li>and</li> <li>Adalimumab to be administered at doses no greater than 40 mg every 14 days</li> </ul>				
CONTINUATION – Behcet's disease – severe Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant p NZ Hospital.	practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health			
O The patient has had a good clinical response and O Adalimumab to be administered at doses no	se to treatment with measurably improved quality of life o greater than 40 mg every 14 days			
INITIATION – Hidradenitis suppurativa         Re-assessment required after 6 months         Prerequisites (tick boxes where appropriate)         O       Prescribed by, or recommended by a dermatologio or guideline that has been endorsed by the Health and	st or Practitioner on the recommendation of a dermatologist, or in accordance with a protocol n NZ Hospital.			
O The patient has experienced intoleration or O Patient has developed symptoms of lo (Amgevita) and clinician attributes this and O Patient has received a maximum of 6 month and O	ole side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment oss of disease control following a minimum of 4 weeks treatment with adalimumab is loss of disease response to a change in treatment regimen ons treatment with Amgevita rity approval for the Humira brand of adalimumab for this indication			
O Adalimumab to be administered at doses no	o greater than 40 mg every 7 days. Fortnightly dosing has been considered			

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:
Adalimumab (Humira - Alternative brand) - continued	
CONTINUATION – Hidradenitis suppurativa Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a dermatologist or Practitioner or or guideline that has been endorsed by the Health NZ Hospital.	n the recommendation of a dermatologist, or in accordance with a protocol
	ry nodules, abscesses, draining fistulae) of 25% or more from baseline
and Adalimumab is to be administered at doses no greater than 40	
INITIATION – Psoriasis - severe chronic plaque         Re-assessment required after 6 months         Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a dermatologist or Practitioner or or guideline that has been endorsed by the Health NZ Hospital.	n the recommendation of a dermatologist, or in accordance with a protocol
or	m adalimumab (Amgevita) following a minimum of 4 weeks treatment trol following a minimum of 4 weeks treatment with adalimumab esponse to a change in treatment regimen
and O Patient has received a maximum of 6 months treatment with A and	Amgevita
O Patient has previously had a Special Authority approval for the and O Adalimumab to be administered at doses no greater than 40 r	

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.	

PRES	CRIB	ER	PATIENT:
Name	:		Name:
Ward:			NHI:
Adal	imun	nab	(Humira - Alternative brand) - continued
Re-a	ssessr equisi P	ment <b>tes</b> (t rescr	N – Psoriasis - severe chronic plaque required after 6 months tick boxes where appropriate) ibed by, or recommended by a dermatologist or Practitioner on the recommendation of a dermatologist, or in accordance with a protocol deline that has been endorsed by the Health NZ Hospital.
			Patient had "whole body" severe chronic plaque psoriasis at the start of treatment and Following each prior adalimumab treatment course the patient has a PASI score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-adalimumab treatment baseline value Following each prior adalimumab treatment course the patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, when compared with the pre-treatment baseline value
		or	O Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment and O Following each prior adalimumab treatment course the patient has a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the treatment course baseline values O Following each prior adalimumab treatment course the patient has a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-adalimumab treatment baseline value
Re-a	ssessr <b>equisi</b> O P	<b>I – P</b> y nent <b>tes</b> (t	Adalimumab to be administered at doses no greater than 40 mg every 14 days yoderma gangrenosum required after 6 months tick boxes where appropriate) ibed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ al.
	and	or O I	<ul> <li>O The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment</li> <li>O Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen</li> <li>Patient has received a maximum of 6 months treatment with Amgevita</li> </ul>
	and		Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication A maximum of 8 doses

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.	

PRESCRIB	ER PATIENT:
Name:	
Ward:	NHI:
Adalimur	nab (Humira - Alternative brand) - continued
Re-assess Prerequisi	ATION – Pyoderma gangrenosum ment required after 6 months ites (tick boxes where appropriate) Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ dospital.
Re-assess Prerequisi	N – Crohn's disease - adult ment required after 6 months ites (tick boxes where appropriate) Prescribed by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
and ( and (	<ul> <li>O The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita</li> <li>O Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen</li> <li>O Patient has Crohn's and is considered to be at risk of disease destabilisation if there were to be a change to current treatment</li> <li>O Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication</li> <li>O Adalimumab to be administered at doses no greater than 40 mg every 14 days</li> </ul>
Re-assess	ATION – Crohn's disease - adult ment required after 6 months ites (tick boxes where appropriate)
	Prescribed by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
and	O CDAI score has reduced by 100 points from the CDAI score when the patient was initiated on adalimumab or O CDAI score is 150 or less or O The patient has demonstrated an adequate response to treatment, but CDAI score cannot be assessed
	O Adalimumab to be administered at doses no greater than 40 mg every 14 days

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:
Adalimumab (Humira - Alternative brand) - continued	
and protocol or guideline that has been endorsed by the Health NZ Hosp and O The patient has experienced intolerable side effects from and a maximum of 6 months treatment with Amgevita O Patient has developed symptoms of loss of disease con	er on the recommendation of a gastroenterologist, or in accordance with a ital. n adalimumab (Amgevita) following a minimum of 4 weeks treatment, trol following a minimum of 4 weeks treatment, and a maximum of s this loss of disease response to a change in treatment regimen
CONTINUATION – Crohn's disease - children Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a gastroenterologist or Practition protocol or guideline that has been endorsed by the Health NZ Hosp and O PCDAI score has reduced by 10 points from the PCDAI or O PCDAI score is 15 or less or O The patient has demonstrated an adequate response to and O Adalimumab to be administered at doses no greater than 40 m	score when the patient was initiated on adalimumab treatment, but PCDAI score cannot be assessed
INITIATION – Crohn's disease - fistulising Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a gastroenterologist or Practition protocol or guideline that has been endorsed by the Health NZ Hosp and	er on the recommendation of a gastroenterologist, or in accordance with a ital.
or O Patient has developed symptoms of loss of disease con 6 months treatment with Amgevita and clinician attribute	

	Signed:	Date:
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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 Pharmaceutic	al
Schedule. For community funding, see the Special Authority Criteria.	

PRES	SCRIE	BER	PATIENT:			
Name	e:		Name:			
Ward	:		NHI:			
Adalimumab (Humira - Alternative brand) - continued						
CONTINUATION – Crohn's disease - fistulising Re-assessment required after 6 months						
Prer	equis	sites	k boxes where appropriate)			
and		ed by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a or guideline that has been endorsed by the Health NZ Hospital.				
		or	The number of open draining fistulae have decreased from baseline by at least 50%			
			O There has been a marked reduction in drainage of all fistula(e) from baseline as demonstrated by a reduction in the Fistula Assessment score, together with less induration and patient-reported pain			
	and	0	dalimumab to be administered at doses no greater than 40 mg every 14 days			
INITIATION – Ocular inflammation – chronic         Re-assessment required after 12 months         Prerequisites (tick boxes where appropriate)         O       Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been end NZ Hospital.						
and	and	or	<ul> <li>P The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita</li> <li>P Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with Amgevita, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen</li> <li>P Patient has uveitis and is considered to be at risk of vision loss if they were to change treatment</li> </ul>			
	and	0	atient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication dalimumab to be administered at doses no greater than 40 mg every 14 days			
CONTINUATION – Ocular inflammation – chronic Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)						
and	O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Hea NZ Hospital.					
	and	or or	<ul> <li>The patient has had a good clinical response following 12 weeks' initial treatment</li> <li>Following each 12-month treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria &lt; ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema)</li> <li>Following each 12-month treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to &lt; 10mg daily, or steroid drops less than twice daily if under 18 years old</li> </ul>			
O Adalimumab to be administered at doses no greater than 40 mg every 14 days						

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.

PRESCRIE	BER		F	PATIENT:			
Name:				Name:			
Ward:				NHI:			
Adalimu	mak	o (Hu	mira - Alternative brand) - continued				
_			r inflammation – severe ired after 12 months				
Prerequis	Prerequisites (tick boxes where appropriate)						
and	O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.						
The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks and a maximum of 6 months treatment with Amgevita				adalimumab (Amgevita) following a minimum of 4 weeks treatment,			
		0		ol following a minimum of 4 weeks treatment with Amgevita, and a cian attributes this loss of disease response to a change in treatment			
	or	Ο	Patient has uveitis and is considered to be at risk of vision	loss if they were to change treatment			
and O Patient has previously had a Special Authority approval for the Humira brand of adalimumab for the		nt has previously had a Special Authority approval for the F	Humira brand of adalimumab for this indication				
	Adalimumab to be administered at doses no greater than 40 mg every 14 days						
CONTINUATION – Ocular inflammation – severe Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Healt NZ Hospital.							
	or	0	The patient has had a good clinical response following 3 i	initial doses			
	or	0	Following each 12-month treatment period, the patient has Uveitis Nomenclature (SUN) criteria < $\frac{1}{2}$ + anterior chamber resolution of uveitic cystoid macular oedema)	s had a sustained reduction in inflammation (Standardisation of er or vitreous cells, absence of active vitreous or retinal lesions, or			
	U	0	Following each 12-month treatment period, the patient has to < 10mg daily, or steroid drops less than twice daily if un	s a sustained steroid sparing effect, allowing reduction in prednisone ider 18 years old			
and	Adalimumab to be administered at doses no greater than 40 mg every 14 days						

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:					
Adalimumab (Humira - Alternative brand) - continued						
INITIATION – ankylosing spondylitis Re-assessment required after 6 months						
Prerequisites (tick boxes where appropriate)						
	Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.					
or	m adalimumab (Amgevita) following a minimum of 4 weeks treatment					
O Patient has developed symptoms of loss of disease co (Amgevita)	ntrol following a minimum of 4 weeks treatment with adalimumab					
and O Patient has received a maximum of 6 months treatment with and	Amgevita					
O Patient has previously had a Special Authority approval for th	e Humira brand of adalimumab for this indication					
Adalimumab to be administered at doses no greater than 40	mg every 14 days					
Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.						
improvement in BASDAI of 50%, whichever is less	more points from pre-treatment baseline on a 10 point scale, or an					
Adalimumab to be administered at doses no greater than 40	mg every 14 days					
INITIATION – Arthritis – oligoarticular course juvenile idiopathic         Re-assessment required after 6 months         Prerequisites (tick boxes where appropriate)						
O Prescribed by, or recommended by a named specialist or rheumate by the Health NZ Hospital.	ologist, or in accordance with a protocol or guideline that has been endorsed					
or	m adalimumab (Amgevita) following a minimum of 4 weeks treatment ntrol following a minimum of 4 weeks treatment with adalimumab response to a change in treatment regimen					
and O Patient has received a maximum of 6 months treatment with and O Patient has previously had a Special Authority approval for th						

Form RS1922 July 2025	HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST					
Use this checklist to determine if a patient meets the restricti Schedule. For community funding, see the Special Authority	ions for funding in the <b>hospital setting</b> . For more details, refer to y Criteria.	Section H of the Pharmaceutical				
PRESCRIBER	PATIENT:					
Name:	Name:					
Ward:	NHI:					
Adalimumab (Humira - Alternative brand) - co	ontinued					
CONTINUATION – Arthritis – oligoarticular course juve Re-assessment required after 6 months Prerequisites (tick box where appropriate)	anile idiopathic					
O Prescribed by, or recommended by a named spe by the Health NZ Hospital.	ecialist or rheumatologist, or in accordance with a protocol or guid	teline that has been endorsed				
O For patients that demonstrate at least a continuin assessment from baseline	ng 30% improvement in active joint count and continued improve	ment in physician's global				
<b>INITIATION – Arthritis - polyarticular course juvenile id</b> Re-assessment required after 6 months <b>Prerequisites</b> (tick boxes where appropriate)	liopathic					
O Prescribed by, or recommended by a named spe by the Health NZ Hospital.	ecialist or rheumatologist, or in accordance with a protocol or guid	Jeline that has been endorsed				
O The patient has experienced intolera	able side effects from adalimumab (Amgevita) following a minimu	m of 4 weeks treatment				
	O Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen					
and O Patient has received a maximum of 6 mont and						
Patient has previously had a Special Author	prity approval for the Humira brand of adalimumab for this indicat	ion				
CONTINUATION – Arthritis - polyarticular course juven Re-assessment required after 6 months Prerequisites (tick box where appropriate)	nile idiopathic					
O Prescribed by, or recommended by a named spe by the Health NZ Hospital.	ecialist or rheumatologist, or in accordance with a protocol or guid	deline that has been endorsed				
	ng 30% improvement in active joint count and continued improve	ment in physician's global				
INITIATION – Arthritis - psoriatic         Re-assessment required after 6 months         Prerequisites (tick boxes where appropriate)         O       Prescribed by, or recommended by a named spe	ecialist or rheumatologist, or in accordance with a protocol or guid	deline that has been endorsed				
and by the Health NZ Hospital.	able side effects from adalimumab (Amgevita) following a minimu	]				
	loss of disease control following a minimum of 4 weeks treatment is loss of disease response to a change in treatment regimen	nt with adalimumab				
and O Patient has received a maximum of 6 months treatment with Amgevita and						
$\square$	prity approval for the Humira brand of adalimumab for this indicat	ion				

Adalimumab to be administered at doses no greater than 40 mg every 14 days

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.

PRES	CRIBE	PATIENT:				
Name:		Name:				
Ward:		NHI:				
Adali	mum	ab (Humira - Alternative brand) - continued				
Re-as	CONTINUATION – Arthritis - psoriatic Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed					
and	by	he Health NZ Hospital. The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior adalimumab treatment in the opinion of the treating physician				
	and	Adalimumab to be administered at doses no greater than 40 mg every 14 days				
Re-as	sessn	- Arthritis – rheumatoid ent required after 6 months s (tick boxes where appropriate)				
O Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance protocol or guideline that has been endorsed by the Health NZ Hospital.						
		O The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment O Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen				
	and and	Patient has received a maximum of 6 months treatment with Amgevita				
	and	Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication				
		O Adalimumab to be administered at doses no greater than 40 mg every 14 days				
		Patient cannot take concomitant methotrexate and requires doses of adalimumab higher than 40 mg every 14 days to maintain an adequate response				
CONTINUATION – Arthritis – rheumatoid Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)						
and		scribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a tocol or guideline that has been endorsed by the Health NZ Hospital.				
	and	The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior adalimumab treatment in the opinion of the treating physician				
		<ul> <li>Adalimumab to be administered at doses no greater than 40 mg every 14 days</li> <li>Patient cannot take concomitant methotrexate and requires doses of adalimumab higher than 40 mg every 14 days to maintain</li> </ul>				
		an adequate response				

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:		
Adalimumab (Humira - Alternative brand) - continued			
INITIATION – Still's disease – adult-onset (AOSD)         Re-assessment required after 6 months         Prerequisites (tick boxes where appropriate)         O       Prescribed by, or recommended by a rheumatologist or Practitioner protocol or guideline that has been endorsed by the Health NZ Hosp         and			
O The patient has experienced intolerable side effects from	n adalimumab (Amgevita) following a minimum of 4 weeks treatment trol following a minimum of 4 weeks treatment with adalimumab esponse to a change in treatment regimen		
and	<ul> <li>Patient has received a maximum of 6 months treatment with Amgevita</li> <li>Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication</li> </ul>		
CONTINUATION – Still's disease – adult-onset (AOSD)			

Re-assessment required after 6 months **Prerequisites** (tick box where appropriate)

and

Freiequisites (lick box where appropriate)

O Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

The patient has demonstrated a sustained improvement in inflammatory markers and functional status

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.

PRES	SCR	IBER		PATIENT:
Name	ə:			Name:
Ward	:			NHI:
Abc	Abciximab			
INITIATION Prerequisites (tick boxes where appropriate)			(tick boxes where appropriate)	
		0	For use in patients with acute coronary syndromes undergoing	percutaneous coronary intervention
	or	Ο	For use in patients undergoing intra-cranial intervention	

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.

PRESCRI	IBER	PATIENT:	
Name:		Name:	
Ward:		NHI:	
Nivolum	nab		
Re-asses	ON – unresectable or metastatic melanoma ssment required after 4 months isites (tick boxes where appropriate) Prescribed by, or recommended by a relevant specialist or any rele accordance with a protocol or guideline that has been endorsed by	evant practitioner on the recommendation of a relevant specialist, or in / the Health NZ Hospital.	
<ul> <li>The individual has metastatic or unresectable melanoma (excluding uveal) stage III or IV</li> <li>and</li> <li>Baseline measurement of overall tumour burden is documented clinically and radiologically</li> <li>and</li> <li>The individual has ECOG performance 0-2</li> <li>and</li> <li>The individual has not received funded pembrolizumab</li> </ul>			
	or O The individual has received an initial Special Aut within 12 weeks of starting treatment due to intol and O The cancer did not progress while the individual		
and	O The individual has been diagnosed in the metastatic or or O The individual did not receive treatment in the perioper or O The individual received treatment in the perioper and	rative setting with a PD-1/PD-L1 inhibitor	

()The individual did not experience disease recurrence within six months of completing perioperative treatment with a PD-1/PD-L1 inhibitor

and

ESCRIBER			PATIENT:
			Name:
:			NHI:
luma	<b>ab</b> - co	ntinued	
assessr r <b>equisi</b> O P	ment re i <b>tes</b> (tic Prescrib		r any relevant practitioner on the recommendation of a relevant specialist, or in
a	ccorda	nce with a protocol or guideline that has been end	lorsed by the Health NZ Hospital.
		O The individual's disease has had a compor O The individual's disease has had a parti or O The individual has stable disease	
or	and	Response to treatment in target lesions has be treatment period	een determined by comparable radiologic assessment following the most recent
	and and	<ul> <li>progression</li> <li>The individual has signs of disease progression</li> <li>Disease has not progressed during previous to</li> </ul>	
issessr <b>equisi</b> P	ment re ites (tic Prescrib 	- unresectable or metastatic melanoma, more quired after 4 months k boxes where appropriate) ed by, or recommended by a relevant specialist or nee with a protocol or guideline that has been end e individual has been on treatment for more than	r any relevant practitioner on the recommendation of a relevant specialist, or in lorsed by the Health NZ Hospital.
		O The individual's disease has had a or O The individual's disease has had a or O The individual has stable disease	
		$\overline{\mathbf{O}}$	has been determined by comparable radiologic or clinical assessment following
		O The individual has previously discontinu progression	ed treatment with nivolumab for reasons other than severe toxicity or disease

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:

## Nivolumab - continued

or	<b>)</b> Pa	tient i	is currently on treatment with nivolumab and met all remaining criteria prior to commencing treatment
	С	) т	ne patient has metastatic renal cell carcinoma
	and	) т	ne patient is treatment naive
	and	) т	ne patient has ECOG performance status 0-2
	and C and	) т	ne disease is predominantly of clear cell histology
		(	D The patient has sarcomatoid histology
		or (	D Haemoglobin levels less than the lower limit of normal
		or (	Corrected serum calcium level greater than 10 mg/dL (2.5 mmol/L)
		or (	O Neutrophils greater than the upper limit of normal
		or (	O Platelets greater than the upper limit of normal
		or (	O Interval of less than 1 year from original diagnosis to the start of systemic therapy
	1	or (	C Karnofsky performance score of less than or equal to 70

#### **INITIATION – renal cell carcinoma, second line** Re-assessment required after 4 months

**Prerequisites** (tick boxes where appropriate)

C	Patient has metastatic renal-cell carcinoma
and	The disease is of predominant clear-cell histology
and	Patient has ECOG performance status 0-2
and	Patient has documented disease progression following one or two previous regimens of antiangiogenic therapy
and	Patient has not previously received a funded immune checkpoint inhibitor
and	Nivolumab is to be used as monotherapy at a maximum dose of 240 mg every 2 weeks (or equivalent) and discontinued at disease progression

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:
Nivol	uma	ıb -	cont	inued	
Re-as	sessi	men	t requ	enal cell carcinoma ired after 4 months poxes where appropriate)	
	or		Patient's disease has had a complete response to treatment Patient's disease has had a partial response to treatment Patient has stable disease		
	and ( and	С С	Nivo	vidence of disease progression lumab is to be used as monotherapy at a maximum dose o ression	of 240 mg every 2 weeks (or equivalent) and discontinued at disease

## RS2134 - Pembrolizumab

MSI-H/dMMR advanced colorectal cancer - INITIATION	
MSI-H/dMMR advanced colorectal cancer - CONTINUATION	
Urothelial carcinoma - INITIATION	
Urothelial carcinoma - CONTINUATION	
Breast cancer, advanced - INITIATION	
Breast cancer, advanced - CONTINUATION	
Head and neck squamous cell carcinoma - INITIATION	
Head and neck squamous cell carcinoma - CONTINUATION	
Non-small cell lung cancer first-line combination therapy - INITIATION	
Non-small cell lung cancer first-line combination therapy - CONTINUATION	
Non-small cell lung cancer first-line monotherapy - INITIATION	
Non-small cell lung cancer first-line monotherapy - CONTINUATION	
Relapsed/refractory Hodgkin lymphoma - INITIATION	
Relapsed/refractory Hodgkin lymphoma - CONTINUATION	
Stage III or IV resectable melanoma - neoadjuvant - INITIATION	
Stage III or IV resectable melanoma - neoadjuvant - CONTINUATION	
Stage III or IV resected melanoma - adjuvant - INITIATION	
Stage III or IV resected melanoma - adjuvant - CONTINUATION	
Unresectable or metastatic melanoma - INITIATION	
Unresectable or metastatic melanoma, less than 24 months on treatment - CONTINUATION	
Unresectable or metastatic melanoma, more than 24 months on treatment - CONTINUATION	

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:
Pembrolizumab	

	INITIATION – stage III or IV resectable melanoma - neoadjuvant Re-assessment required after 4 months					
	Prerequisites (tick boxes where appropriate)					
and	O Prescribed by, or recommended by a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.					
	or	O The	individual is currently on treatment with pembrolizumab and met all remaining criteria prior to commencing treatment			
		and	The individual has resectable stage IIIB, IIIC, IIID or IV melanoma (excluding uveal) (see note)			
		0	The individual has not received prior funded systemic treatment in the perioperative setting for their stage IIIB, IIIC, IIID or IV melanoma			
		and O and	Treatment must be prior to complete surgical resection			
		and	Pembrolizumab must be administered as monotherapy			
		and	The individual has ECOG performance score 0-2			
			Pembrolizumab to be administered at a fixed dose of 200 mg every 3 weeks (or equivalent)			

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.

PRES	SCRI	BER		PATIENT:	
Name	:			Name:	
Ward				NHI:	
Pem	brol	lizumab	- continued		
Re-a	sses	sment requ	tage III or IV resectable melanoma - neoadjuvant ired after 4 months oxes where appropriate)		
O Prescribed by, or recommended by a relevant specialist or any relevant practitioner on the recommendation of a relevant special accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.					
		and	The individual has received neoadjuvant treatment with	an immune checkpoint inhibitor	
	or	0	The individual meets initiation criteria for pembrolizumat	o for stage III or IV resected melanoma – adjuvant	
	01	and	The individual has received neoadjuvant and adjuvant tr	eatment with an immune checkpoint inhibitor	
		0	The individual meets continuation criteria for pembrolizu	mab for stage III or IV resected melanoma – adjuvant	
	or	() and	The individual has received neoadjuvant and adjuvant tr	eatment with an immune checkpoint inhibitor	
		and	The individual has metastatic or unresectable melanoma	a (excluding uveal) stage III or IV	
	or	0	The individual meets initiation criteria for pembrolizumat	o for unresectable or metastatic melanoma	
	U	and	The individual has received neoadjuvant and adjuvant tr	eatment with an immune checkpoint inhibitor	
		and	The individual has received treatment with an immune c	heckpoint inhibitor for unresectable or metastatic melanoma	
		Ο	The individual meets continuation criteria for pembrolizu	mab for unresectable or metastatic melanoma	
Note	:				
a) S	a) Stage IIIB, IIIC, IIID or IV melanoma defined as per American Joint Committee on Cancer (AJCC) 8th Edition				

b) Initiating treatment within 13 weeks of complete surgical resection means either 13 weeks after resection (primary or lymphadenectomy) or 13 weeks prior to the scheduled date of the resection (primary or lymphadenectomy)

I confirm that the above details are correct:

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

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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.

PRES	CRIE	BER		PATIENT:		
Name	:			Name:		
Ward:				NHI:		
Pem	brol	lizumal	<b>b</b> - continued			
			ge III or IV resected melanoma - adjuvant quired after 4 months			
Prere	equis	sites (ticl	k boxes where appropriate)			
( and	O Prescribed by, or recommended by a relevant specialist or any relevant accordance with a protocol or guideline that has been endorsed by the					
	or	O Th	e individual is currently on treatment with pembrolizumab a	nd met all remaining criteria prior to commencing treatment		
		and	${\sf O}$ The individual has resected stage IIIB, IIIC, IIID or IV me	elanoma (excluding uveal) (see note a)		
		C	O Adjuvant treatment with pembrolizumab is required			
		and	D The individual has not received prior funded systemic tre	eatment in the adjuvant setting for stage IIIB, IIIC, IIID or IV melanoma		
		and	D Treatment must be in addition to complete surgical resea	ction		
		and	Treatment must be initiated within 13 weeks of complete recovery (see note b)	e surgical resection, unless delay is necessary due to post-surgery		
		and and	Pembrolizumab must be administered as monotherapy			
			The individual has ECOG performance score 0-2			
		and	Pembrolizumab to be administered at a fixed dose of 20	0 mg every 3 weeks (or equivalent)		
Note	Note:					

a) Stage IIIB, IIIC, IIID or IV melanoma defined as per American Joint Committee on Cancer (AJCC) 8th Edition

b) Initiating treatment within 13 weeks of complete surgical resection means 13 weeks after resection (primary or lymphadenectomy)

I confirm that the above of	details are correct:
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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		P/	ATIENT:	
Name	e:		Na	ame:
Ward	:		Ni	Ні:
Pem	broli	izumab	- continued	
Re-a	ssess	sment requ	stage III or IV resected melanoma - adjuvant nired after 4 months poxes where appropriate)	
(and	J F	Prescribed		practitioner on the recommendation of a relevant specialist, or in Health NZ Hospital.
		and and	No evidence of disease recurrence Pembrolizumab must be administered as monotherapy	
		and	total treatment course, including any systemic neoadjuvant	e or at completion of 12 months total treatment course (equivalent to
	or	and and and	The individual has received adjuvant treatment with an imm The individual has metastatic or unresectable melanoma (e The individual meets initiation criteria for pembrolizumab fo	excluding uveal) stage III or IV
	or	and and	The individual has received adjuvant treatment with an imm The individual has received treatment with an immune check	ckpoint inhibitor for unresectable or metastatic melanoma
			The individual meets continuation criteria for pembrolizuma	ID TOR UNRESECTABLE OF METASTATIC MEIANOMA

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:		
Pembrolizumab - continued			
INITIATION – unresectable or metastatic melanoma Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)			
O Prescribed by, or recommended by a relevant specialist or any relevant accordance with a protocol or guideline that has been endorsed by t and			
<ul> <li>The individual has metastatic or unresectable melanoma (excland)</li> <li>Baseline measurement of overall tumour burden is documenter and</li> <li>The individual has ECOG performance 0-2</li> <li>The individual has not received funded nivolumab</li> <li>The individual has received an initial Special Auth 12 weeks of starting treatment due to intolerance</li> <li>The cancer did not progress while the individual weight of the individual has received an initial Special Auth 12 weeks of starting treatment due to intolerance</li> </ul>	ed clinically and radiologically		
and	tive setting with a PD-1/PD-L1 inhibitor		

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.	

PATIENT:	RESCRIBER	PRES	
Name:	lame: Name:		
NHI:	lard:	Ward	
	embrolizuma	Pem	
appropriate)	Re-assessment re Prerequisites (tio	Re-a	
nmended by a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in ocol or guideline that has been endorsed by the Health NZ Hospital.	accorda	and	
individual's disease has had a complete response to treatment individual's disease has had a partial response to treatment individual has stable disease to treatment in target lesions has been determined by comparable radiologic assessment following the most recent beriod	or (and		
ual has signs of disease progression as not progressed during previous treatment with pembrolizumab	and		
	CONTINUATION Re-assessment re Prerequisites (tio	Re-a	
nmended by a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in ocol or guideline that has been endorsed by the Health NZ Hospital.	accorda	( and	
as been on treatment for more than 24 months	O T		
The individual's disease has had a complete response to treatment The individual's disease has had a partial response to treatment The individual has stable disease ponse to treatment in target lesions has been determined by comparable radiologic or clinical assessment following nost recent treatment period treatment remains clinically appropriate and the individual is benefitting from the treatment individual has previously discontinued treatment with pembrolizumab for reasons other than severe toxicity or ase progression individual has signs of disease progression ase has not progressed during previous treatment with pembrolizumab	or		
months appropriate) Inmended by a relevant specialist or any relevant practitioner on the recommendation of a relevant special cool or guideline that has been endorsed by the Health NZ Hospital. Its been on treatment for more than 24 months The individual's disease has had a complete response to treatment The individual's disease has had a partial response to treatment The individual has stable disease bonse to treatment in target lesions has been determined by comparable radiologic or clinical assessmost recent treatment period treatment remains clinically appropriate and the individual is benefitting from the treatment individual has previously discontinued treatment with pembrolizumab for reasons other than severe to ase progression individual has signs of disease progression	Re-assessment roprerequisites (tide) Prescribut accordation and Transformed Tr	Re-a Prer	

#### 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.

RESCRIBER PATIENT:		
Name:	Name:	
Ward:	NHI:	
Pembrolizumab - continued		
INITIATION – non-small cell lung cancer first-line monotherapy Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)		
O Prescribed by, or recommended by a medical oncologist or any release accordance with a protocol or guideline that has been endorsed by and	vant practitioner on the recommendation of a medical oncologist, or in the Health NZ Hospital.	
O Patient has locally advanced or metastatic, unresectable, non and	-small cell lung cancer	
O Patient has not had chemotherapy for their disease in the pall	iative setting	
O Patient has not received prior funded treatment with an immu	ne checkpoint inhibitor for NSCLC	
EGFR or ALK tyrosine kinase unless not possible to ascertain	tion confirming that the disease does not express activating mutations of	
and O Pembrolizumab to be used as monotherapy and		
O There is documentation confirming the disease express validated test unless not possible to ascertain	es PD-L1 at a level greater than or equal to 50% as determined by a	
O There is documentation confirming the disease ex by a validated test unless not possible to ascertain	xpresses PD-L1 at a level greater than or equal to 1% as determined	
	interest of the patient based on clinician assessment	
and O Patient has an ECOG 0-2		
O Pembrolizumab to be used at a maximum dose of 200 mg eve	ery three weeks (or equivalent) for a maximum of 16 weeks	
Baseline measurement of overall tumour burden is documente	ed clinically and radiologically	

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.

PRES	CRIBER	PATIENT:
Name	:	Name:
Ward:		NHI:
Pem	brolizu	mab - continued
Re-a	ssessmer	DN – non-small cell lung cancer first-line monotherapy tt required after 4 months (tick boxes where appropriate)
( and		cribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in rdance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	or	O Patient's disease has had a complete response to treatment
	or	<ul> <li>Patient's disease has had a partial response to treatment</li> <li>Patient has stable disease</li> </ul>
	and	Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period
	and and	No evidence of disease progression
	and	The treatment remains clinically appropriate and patient is benefitting from treatment
	and _	Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent)
		Treatment with pembrolizumab to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks)
Re-a	ssessmer	non-small cell lung cancer first-line combination therapy nt required after 4 months (tick boxes where appropriate)
( and		cribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in rdance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
		Patient has locally advanced or metastatic, unresectable, non-small cell lung cancer
	and	The patient has not had chemotherapy for their disease in the palliative setting
	and	Patient has not received prior funded treatment with an immune checkpoint inhibitor for NSCLC
	and	For patients with non-squamous histology there is documentation confirming that the disease does not express activating mutations of EGFR or ALK tyrosine kinase unless not possible to ascertain
	and	Pembrolizumab to be used in combination with platinum-based chemotherapy
	and	Patient has an ECOG 0-2
	and	Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent) for a maximum of 16 weeks
		Baseline measurement of overall tumour burden is documented clinically and radiologically

Use this checklist to determine if a patient meets the restrictions for funding in the <b>hospital setting</b> . For more details, refer to Section H of the Pharmaceutical Schedule. For community funding, see the Special Authority Criteria.				
PRESCRIBER	PATIENT:			
Name:	Name:			

#### Pembrolizumab - continued

Re-a	sses	smen	t requ	non-small cell lung cancer first-line combination therapy nired after 4 months poxes where appropriate)
( and	С	Preso	ribed	by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in e with a protocol or guideline that has been endorsed by the Health NZ Hospital.
			Ο	Patient's disease has had a complete response to treatment
		or	Ο	Patient's disease has had a partial response to treatment
		or	Ο	Patient has stable disease
	and and	0		ponse to treatment in target lesions has been determined by comparable radiologic assessment following the most recent ment period
	and	Ο	No e	vidence of disease progression
	and	Ο	The	treatment remains clinically appropriate and patient is benefitting from treatment
	and	Ο	Pem	brolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent)
	and	0		tment with pembrolizumab to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed y 3 weeks)
Prer ( and	С	Preso	ribed	boxes where appropriate) by, or recommended by a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in e with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	or	0	Patie	ent is currently on treatment with pembrolizumab and met all remaining criteria prior to commencing treatment
			or	O Patient has recurrent or de novo unresectable, inoperable locally advanced triple-negative breast cancer (that does not express ER, PR or HER2 IHC3+ or ISH+ [including FISH or other technology])
				O Patient has recurrent or de novo metastatic triple-negative breast cancer (that does not express ER, PR or HER2 IHC3+ or ISH+ [including FISH or other technology]
		an	d O	Patient is treated with palliative intent
		an	Q	Patient's cancer has confirmed PD-L1 Combined Positive Score (CPS) is greater than or equal to 10
		an	Ο	Patient has received no prior systemic therapy in the palliative setting
		an	Ο	Patient has an ECOG score of 0-2
		an	Ο	Pembrolizumab is to be used in combination with chemotherapy
		an	Ο	Baseline measurement of overall tumour burden is documented clinically and radiologically
		an	Ö	Pembrolizumab is to be used at a maximum dose of 200 mg every three weeks (or equivalent) for a maximum of 16 weeks

Signed:		Date:	
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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.

PRES	SCRIB	ER	PATIENT:
Name	ə:		Name:
Ward	:		NHI:
Pem	broli	izun	nab - continued
Re-a	assess	men	DN – breast cancer, advanced t required after 6 months (tick boxes where appropriate)
and			cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.
		or	O Patient's disease has had a complete response to treatment
		or	O Patient's disease has had a partial response to treatment
			O Patient has stable disease
	and ( and	О	No evidence of disease progression
	( and	0	Response to treatment in target lesions has been determined by a comparable radiologic assessment following the most recent treatment period
	and	Ο	Pembrolizumab is to be used at a maximum dose of 200 mg every three weeks (or equivalent)
	(	0	Treatment with pembrolizumab is to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks)
Re-a	assess	men	nead and neck squamous cell carcinoma t required after 4 months (tick boxes where appropriate)
and	Р a	Presc	cribed by, or recommended by a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in rdance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
-	( or	О	Patient is currently on treatment with pembrolizumab and met all remaining criteria prior to commencing treatment
		and	O Patient has recurrent or metastatic head and neck squamous cell carcinoma of mucosal origin (excluding nasopharyngeal carcinoma) that is incurable by local therapies
		and	O Patient has not received prior systemic therapy in the recurrent or metastatic setting
		and	O Patient has a positive PD-L1 combined positive score (CPS) of greater than or equal to 1
		and	O Patient has an ECOG performance score of 0-2
			O Pembrolizumab to be used in combination with platinum-based chemotherapy
			or O Pembrolizumab to be used as monotherapy
		and	Pembrolizumab is to be used at a maximum dose of 200 mg every three weeks (or equivalent) for a maximum of 16 weeks

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.

PRES	CRIB	ER		PATIENT:
Name	Name:			Name:
Ward:				NHI:
Pem	broli	izun	nab	- continued
Re-a	ssess	ment	requ	ead and neck squamous cell carcinoma ired after 4 months oxes where appropriate)
( and			ribed ospita	by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health I.
		or or	0 0 0	Patient's disease has had a complete response to treatment Patient's disease has had a partial response to treatment Patient has stable disease
	and ( and ( and	0	Peml Treat	vidence of disease progression prolizumab is to be used at a maximum dose of 200 mg every three weeks (or equivalent) ment with pembrolizumab is to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed v 3 weeks)
Re-a	ssess equisi	ites ( Presc	t requ (tick b ribed dance	/dMMR advanced colorectal cancer ired after 4 months oxes where appropriate)         by, or recommended by a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in e with a protocol or guideline that has been endorsed by the Health NZ Hospital.         dual is currently on treatment with pembrolizumab and met all remaining criteria prior to commencing treatment         O       Individual has deficient mismatch repair (dMMR) or microsatellite instability-high (MSI-H) metastatic colorectal cancer
		anc anc anc anc anc		O Individual has deficient mismatch repair (dMMR) or microsatellite instability-high (MSI-H) unresectable colorectal cancer Individual is treated with palliative intent Individual has not previously received funded treatment with pembrolizumab for MSI-H/dMMR advanced colorectal cancer Individual has an ECOG performance score of 0-2 Baseline measurement of overall tumour burden is documented clinically and radiologically Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent) for a maximum of 16 weeks

#### 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.

PRESC	RIBER PATIENT:
Name:	Name:
Ward:	NHI:
Pemb	rolizumab - continued
Re-ass Prerect	NUATION – MSI-H/dMMR advanced colorectal cancer essment required after 4 months juisites (tick boxes where appropriate) Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. No evidence of disease progression Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent) and Treatment with pembrolizumab is to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks)
Re-ass	FION – Urothelial carcinoma essment required after 4 months juisites (tick boxes where appropriate)
and	Prescribed by, or recommended by a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
c	O Patient is currently on treatment with pembrolizumab and met all remaining criteria prior to commencing treatment
	O Patient has inoperable locally advanced (T4) or metastatic urothelial carcinoma and
	O Patient has an ECOG performance score of 0-2 and
	O Patient has documented disease progression following treatment with chemotherapy and
	O Pembrolizumab to be used as monotherapy at a maximum dose of 200 mg every three weeks (or equivalent) for a maximum of 16 weeks
Re-ass	NUATION – Urothelial carcinoma essment required after 4 months uisites (tick boxes where appropriate)
and	Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	O Patient's disease has had a complete response to treatment
	or O Patient's disease has had a partial response to treatment
	or O Patient has stable disease
	O No evidence of disease progression
	O Pembrolizumab is to be used as monotherapy at a maximum dose of 200 mg every three weeks (or equivalent)
	O Treatment with pembrolizumab is to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks)

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.

PRESC	RIBER	PATIENT:
Name:		Name:
Ward:		NHI:

## Pembrolizumab - continued

Re-assessmen	relapsed/refractory Hodgkin lymphoma It required after 4 months (tick boxes where appropriate)	
	cribed by, or recommended by a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in rdance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	
or O	Individual is currently on treatment with pembrolizumab and met all remaining criteria prior to commencing treatment	
	O Individual has relapsed/refractory Hodgkin lymphoma after two or more lines of chemotherapy	
	O Individual is ineligible for autologous stem cell transplant	
	or O Individual has relapsed/refractory Hodgkin lymphoma and has previously undergone an autologous stem cell transplant	
and	O Individual has not previously received funded pembrolizumab for relapsed/refractory Hodgkin lymphoma	
	O Pembrolizumab to be administered at doses no greater than 200 mg once every 3 weeks	
Re-assessmen	DN – relapsed/refractory Hodgkin lymphoma It required after 6 months (tick boxes where appropriate)	
	cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health lospital.	
and	Patient has received a partial or complete response to pembrolizumab	
	Treatment with pembrolizumab is to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed	

Treatment with pembrolizumab is to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks)

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:
Durvalumab	

#### **INITIATION – Non-small cell lung cancer** Re-assessment required after 4 months Prerequisites (tick boxes where appropriate) ( ) Patient has histologically or cytologically documented stage III, locally advanced, unresectable non-small cell lung cancer (NSCLC) or Patient has histologically or cytologically documented stage IIb (T1N2a only), locally advanced, unresectable non-small cell lung cancer (NSCLC) and ) Patient has received two or more cycles of platinum-based chemotherapy concurrently with definitive radiation therapy and Patient has no disease progression following the second or subsequent cycle of platinum-based chemotherapy with definitive radiation therapy treatment and Patient has a ECOG performance status of 0 or 1 and Patient has completed last radiation dose within 8 weeks of starting treatment with durvalumab and ()Patient must not have received prior PD-1 or PD-L1 inhibitor therapy for this condition and Durvalumab is to be used at a maximum dose of no greater than 10 mg/kg every 2 weeks or Durvalumab is to be used at a flat dose of 1500 mg every 4 weeks and ( ) Treatment with durvalumab to cease upon signs of disease progression

**CONTINUATION – Non-small cell lung cancer** Re-assessment required after 4 months

	~	
( and	C	The treatment remains clinically appropriate and the patient is benefitting from treatment
(		O Durvalumab is to be used at a maximum dose of no greater than 10 mg/kg every 2 weeks
	or	O Durvalumab is to be used at a flat dose of 1500 mg every 4 weeks
and (	С	Treatment with durvalumab to cease upon signs of disease progression
and (	С	Total continuous treatment duration must not exceed 12 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.

PRES	CRIBE	ER	BER PATIENT:	
Name	Name:			
Ward	Vard: NHI:			
Atez	olizuı	ma	ımab	
ΙΝΙΤΙ	ATION	– r	N – non-small cell lung cancer second line monotherapy	
			ment required after 4 months	
Prer	equisit	es	ites (tick boxes where appropriate)	
( and			Prescribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	a medical oncologist, or in
	and	)	O Patient has locally advanced or metastatic non-small cell lung cancer	
	and	)	O Patient has not received prior funded treatment with an immune checkpoint inhibitor for NSCLC	
	and	)	O For patients with non-squamous histology there is documentation confirming that the disease does not ex EGFR or ALK tyrosine kinase unless not possible to ascertain	press activating mutations of
	(	)	O Patient has an ECOG 0-2	
	and	)	m O Patient has documented disease progression following treatment with at least two cycles of platinum-base	ed chemotherapy
	and	)	m O Atezolizumab is to be used as monotherapy at a dose of 1200 mg every three weeks (or equivalent) for a	maximum of 16 weeks
	and	$\mathbf{)}$	O Baseline measurement of overall tumour burden is documented clinically and radiologically	
				)
			ATION – non-small cell lung cancer second line monotherapy ment required after 4 months	
			ites (tick boxes where appropriate)	
( and			Prescribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	a medical oncologist, or in
			O Patient's disease has had a complete response to treatment	
		or	O Patient's disease has had a partial response to treatment	
		or	or O Patient has stable disease	
	and			]
	C	)	O Response to treatment in target lesions has been determined by comparable radiologic assessment follow treatment period	ving the most recent
	and	)	O No evidence of disease progression	
	and	)	m O The treatment remains clinically appropriate and patient is benefitting from treatment	
	and	)	m O Atezolizumab to be used at a maximum dose of 1200 mg every three weeks (or equivalent)	
	and	)	O Treatment with atezolizumab to cease after a total duration of 24 months from commencement (or equiva 3 weeks)	alent of 35 cycles dosed every

#### 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:	Name:	
Ward:	NHI:	

## Atezolizumab - continued

or (	С г	Patient is currently on treatment with atezolizumab and met all remaining criteria prior to commencing treatment
	(	O Patient has locally advanced or metastatic, unresectable hepatocellular carcinoma
	and	O Patient has preserved liver function (Child-Pugh A)
	and	$\sim$
	and	O Transarterial chemoembolisation (TACE) is unsuitable
		O Patient has not received prior systemic therapy for the treatment of hepatocellular carcinoma
		or O Patient received funded lenvatinib before 1 March 2025
		O Patient has experienced treatment-limiting toxicity from treatment with lenvatinib
		O No disease progression since initiation of lenvatinib
	and	O Patient has an ECOG performance status of 0-2
	and	O To be given in combination with bevacizumab

Re-assessment required after 6 months **Prerequisites** (tick box where appropriate)

(lick box where appropriate)

O No evidence of disease progression

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:

## Ipilimumab

or C	) The	ne patient is currently on treatment with ipilimumab and met all remaining criteria prior to commencing treatment
	C	D The patient has metastatic renal cell carcinoma
	and C	D The patient is treatment naive
	and C	The patient has ECOG performance status 0-2
	and C	D The disease is predominantly of clear cell histology
c	and	O The patient has sarcomatoid histology
	C	or O Haemoglobin levels less than the lower limit of normal
		O Corrected serum calcium level greater than 10 mg/dL (2.5 mmol/L)
		or O Neutrophils greater than the upper limit of normal
		or O Platelets greater than the upper limit of normal
		or O Interval of less than 1 year from original diagnosis to the start of systemic therapy
	C	or O Karnofsky performance score of less than or equal to 70

	y 2025 HOSPITAL MEI	
Use t	e this checklist to determine if a patient meets the restrictions for funding in the nedule. For community funding, see the Special Authority Criteria.	
PRE	ESCRIBER	ATIENT:
Nam	me: N	lame:
Ward	rd: N	IHI:
Eve	erolimus	
Re-a	ITIATION e-assessment required after 3 months erequisites (tick boxes where appropriate) O Prescribed by, or recommended by a neurologist or oncologist, or in ad Health NZ Hospital.	
	e-assessment required after 12 months rerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a neurologist or oncologist, or in ac Health NZ Hospital.	ecordance with a protocol or guideline that has been endorsed by the
	O Documented evidence of SEGA reduction or stabilisation by MR and O The treatment remains appropriate and the patient is benefiting and O Everolimus to be discontinued at progression of SEGAs	
Re-a	ITIATION – renal cell carcinoma e-assessment required after 4 months rerequisites (tick boxes where appropriate)	
	<ul> <li>The patient has metastatic renal cell carcinoma</li> <li>The disease is of predominant clear-cell histology</li> <li>The patient has documented disease progression following</li> <li>The patient has an ECOG performance status of 0-2</li> <li>Everolimus is to be used in combination with lenvatinib</li> </ul>	g one previous line of treatment

or

O Patient has received funded treatment with nivolumab for the second line treatment of metastatic renal cell carcinoma and

Patient has experienced treatment limiting toxicity from treatment with nivolumab  $\mathbf{O}$ 

Everolimus is to be used in combination with lenvatinib

Ο There is no evidence of disease progression

# **CONTINUATION – renal cell carcinoma** Re-assessment required after 4 months

and

and

Prerequisites (tick box where appropriate)

O There is no evidence of disease progression

Signed: Date:	
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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.	

PATIENT:	
Name:	
NHI:	
atment as defined by refractory rejection; or intolerant to calcineurin inhibitor	
mation* protherapy and surgery therapy and surgery are not considered clinically appropriate r to consideration of surgery alformation multi-disciplinary team persion 1.1 (see Note)	
ons*	
se or a partial response to treatment, or patient has stable disease ally and disease response to treatment has been clearly documents in	

Signed: Date: .	
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PRESCRIBER	PATIENT:
Name:	Name:
Nard:	NHI:
Sirolimus - continued	
INITIATION – renal angiomyolipoma(s) associated with tuberous Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a nephrologist or urolog Health NZ Hospital. and O Patient has tuberous sclerosis complex*	s sclerosis complex*
and Evidence of renal angiomyolipoma(s) measuring 3 cm	n or greater and that have shown interval growth
CONTINUATION – renal angiomyolipoma(s) associated with tube Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	erous sclerosis complex*
and Demonstrated stabilisation or improvement in renal fu	emorrhage or significant adverse effects to sirolimus treatment
Note: Indications marked with * are unapproved indications	)
Hospital.	osis complex*
and O Patient has epilepsy with a background of documente	ed tuberous sclerosis complex*
	y, or the patient has experienced unacceptable side effects from, optimal g: sodium valproate, topiramate, levetiracetam, carbamazepine, lamotrigine,
	y, or the patient has experienced unacceptable side effects from, optimal ing: sodium valproate, topiramate, levetiracetam, carbamazepine, lamotrigine, Note)
and O Seizures have a significant impact on quality of life and O Patient has been assessed and surgery is considered benefit from mTOR inhibitor treatment prior to surgery	d inappropriate for this patient, or the patient has been assessed and would

 $\bigcirc$ 

and

#### 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:			
Sirolimus - continued				
CONTINUATION – refractory seizures associated with tuberous sclerosis complex* Re-assessment required after 12 months				

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

Demonstrated significant and sustained improvement in seizure rate (e.g. 50% reduction in seizure frequency) or severity and/or patient quality of life compared with baseline prior to starting sirolimus treatment Note: Indications marked with \* are unapproved indications

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:
Bacillus calmette-guerin (BCG)	
Prerequisites (tick box where appropriate)	
O For use in bladder cancer	

## RS2120 - Upadacitinib

Atopic dermatitis - INITIATION	462
Atopic dermatitis - CONTINUATION	
Crohn's disease - adult - INITIATION	
Crohn's disease - adult - CONTINUATION	
Crohn's disease - children - INITIATION	
Crohn's disease – children - CONTINUATION	
Rheumatoid Arthritis - CONTINUATION	
Rheumatoid Arthritis (patients previously treated with adalimumab or etanercept) - INITIATION	
Ulcerative colitis - INITIATION	
Ulcerative colitis - CONTINUATION	

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:

## Upadacitinib

	~	
( and	)	The individual has had an initial Special Authority approval for adalimumab and/or etanercept for rheumatoid arthritis
	or	O The individual has experienced intolerable side effects with adalimumab and/or etanercept
		O The individual has received insufficient benefit from at least a three-month trial of adalimumab and/or etanercept such that the do not meet the renewal criteria for rheumatoid arthritis
and		O Rituximab is not clinically appropriate
	or	O The individual is seronegative for both anti-cyclic citrullinated peptide (CCP) antibodies and rheumatoid factor
	or	
		O The individual has been started on rituximab for rheumatoid arthritis in a Health NZ Hospital and
		O The individual has experienced intolerable side effects with rituximab
		Or At four months following the initial course of rituximab the individual has received insufficient benefit such that they do not meet the renewal criteria for rheumatoid arthritis
	es (	required after 6 months (tick boxes where appropriate) Following 6 months' initial treatment, the individual has experienced at least a 50% decrease in active joint count from baseline
	ies (	(tick boxes where appropriate)
or or	<b>bes</b> (	(tick boxes where appropriate) Following 6 months' initial treatment, the individual has experienced at least a 50% decrease in active joint count from baseline On subsequent reapplications, the individual has experienced at least a continuing 30% improvement in active joint count from
quisite or TION sessm quisite	ies (	(tick boxes where appropriate) Following 6 months' initial treatment, the individual has experienced at least a 50% decrease in active joint count from baseline On subsequent reapplications, the individual has experienced at least a continuing 30% improvement in active joint count from baseline topic dermatitis required after 6 months (tick boxes where appropriate)
quisit or TION sessin quisit or	ces (	(tick boxes where appropriate) Following 6 months' initial treatment, the individual has experienced at least a 50% decrease in active joint count from baseline On subsequent reapplications, the individual has experienced at least a continuing 30% improvement in active joint count from baseline topic dermatitis required after 6 months (tick boxes where appropriate) Individual is currently on treatment with upadacitinib for atopic dermatitis and met all remaining criteria prior to commencing treatment O Individual has moderate to severe atopic dermatitis, severity as defined by an Eczema Area and Severity Index (EASI) score of greater than or equal to 16 or a Dermatology Life Quality Index (DLQI) score of greater than or equal to 10
or TION sessm quisit	and	(tick boxes where appropriate) Following 6 months' initial treatment, the individual has experienced at least a 50% decrease in active joint count from baseline On subsequent reapplications, the individual has experienced at least a continuing 30% improvement in active joint count from baseline <b>topic dermatitis</b> required after 6 months (tick boxes where appropriate) Individual has moderate to severe atopic dermatitis, severity as defined by an Eczema Area and Severity Index (EASI) score of greater than or equal to 16 or a Dermatology Life Quality Index (DLQI) score of greater than or equal to 10 Individual has received insufficient benefit from topical therapy (including topical corticosteroids or topical calcineurin inhibitors for a 28-day trial within the last 6 months, unless contraindicated to all
quisiti	and	tick boxes where appropriate) Following 6 months' initial treatment, the individual has experienced at least a 50% decrease in active joint count from baseline On subsequent reapplications, the individual has experienced at least a continuing 30% improvement in active joint count from baseline topic dermatitis required after 6 months tick boxes where appropriate) Individual is currently on treatment with upadacitinib for atopic dermatitis and met all remaining criteria prior to commencing treatme Individual has moderate to severe atopic dermatitis, severity as defined by an Eczema Area and Severity Index (EASI) score of greater than or equal to 16 or a Dermatology Life Quality Index (DLQI) score of greater than or equal to 10 Individual has received insufficient benefit from topical therapy (including topical corticosteroids or topical calcineurin inhibitors for a 28-day trial within the last 6 months, unless contraindicated to all Individual has trialled and received insufficient benefit from at least one systemic therapy for a minimum of three months (eg ciclosporin, azathioprine, methotrexate or mycophenolate mofetil), unless contraindicated to all
or ATION assessm quisit	and	tick boxes where appropriate) Following 6 months' initial treatment, the individual has experienced at least a 50% decrease in active joint count from baseline On subsequent reapplications, the individual has experienced at least a continuing 30% improvement in active joint count from baseline topic dermatitis required after 6 months tick boxes where appropriate) Individual is currently on treatment with upadacitinib for atopic dermatitis and met all remaining criteria prior to commencing treatment of Individual has moderate to severe atopic dermatitis, severity as defined by an Eczema Area and Severity Index (EASI) score of greater than or equal to 16 or a Dermatology Life Quality Index (DLQI) score of greater than or equal to 10 Individual has received insufficient benefit from topical therapy (including topical corticosteroids or topical calcineurin inhibitors for a 28-day trial within the last 6 months, unless contraindicated to all

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:	
Upadacitinib - continued		
CONTINUATION – Atopic dermatitis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Individual has received a 75% or greater reduction in EASI sco upadacitinib or O Individual has received a DLQI improvement of 4 or more as c	ore (EASI 75) as compared to baseline EASI prior to commencing ompared to baseline DLQI prior to commencing upadacitinib	
INITIATION – Crohn's disease – adult Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)		
Individual is currently on treatment with upadacitinib for Crohn's disease and met all remaining criteria prior to commencing treatment or or Individual has active Crohn's disease and Individual has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria or Individual meets the initiation criteria for prior biologic therapies for Crohn's disease and O Individual meets the initiation criteria for prior biologic therapies for Crohn's disease O ther biologic therapies for Crohn's disease are contraindicated		
CONTINUATION – Crohn's disease – adult Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)		
O       CDAI score has reduced by 100 points from the CDAI score w         or       O         or       O         O       CDAI score has reduced by 3 points from when individual was in         or       O         O       CDAI score is 150 or less         or       O         HBI score is 4 or less         or       O         The individual has experienced an adequate response to treat	nitiated on biologic therapy	

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:
Upadacitinib - continued	
INITIATION – Crohn's disease – children Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O Individual is currently on treatment with upadacitinib for Crohr	n's disease and met all remaining criteria prior to commencing treatment
Child has active Crohn's disease	
O Child has had an initial approval for prior biologic effects or insufficient benefit to meet renewal crite	therapy for Crohn's disease and has experienced intolerable side ria
Child meets the initiation criteria for prior bio	ologic therapies for Crohn's disease
O Other biologic therapies for Crohn's disease	e are contraindicated
CONTINUATION – Crohn's disease – children Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)	
O PCDAI score has reduced by 10 points from when the child w	as initiated on treatment
or O PCDAI score is 15 or less	
O The child has experienced an adequate response to treatment, but PCDAI score cannot be assessed	
Note: Indications marked with * are unapproved indications.	
INITIATION – Ulcerative colitis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O Individual is currently on treatment with upadacitinib for ulcera	ative colitis and met all remaining criteria prior to commencing treatment
Individual has active ulcerative colitis	

or Individual has had an initial approval for prior biologic therapy for ulcerative colitis and has experienced intolerable side effects or insufficient benefit to meet renewal criteria
O Individual meets the initiation criteria for prior biologic therapies for ulcerative colitis
and
O Other biologic therapies for ulcerative colitis are contraindicated

#### **CONTINUATION – Ulcerative colitis** Re-assessment required after 2 years

or O

Prerequisites (tick boxes where appropriate)

O The SCCAI score has reduced by 2 points or more from the SCCAI score when the individual was initiated on treatment

PUCAI score has reduced by 10 points or more from the PUCAI score when the individual was initiated on treatment

	Signed:	Date:
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**Respiratory System and Allergies** 

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:			
Icatibant							
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a clinical immunologist or relevant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.							
	and		Supply for anticipated emergency treatment of laryngeal/oro-pharyngeal or severe abdominal attacks of acute hereditary angioedema (HAE) for patients with confirmed diagnosis of C1-esterase inhibitor deficiency				
	0	Ō	The patient has undergone product training and has agreed up	oon an action plan for self-administration			

#### CONTINUATION

Re-assessment required after 12 months Prerequisites (tick box where appropriate)

O The treatment remains appropriate and the patient is benefiting from treatment

or

## 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:				
Adrenaline					
INITIATION – anaphylaxis           Prerequisites (tick boxes where appropriate)					
O Patient has experienced a previous anaphylactic reaction which	ch has resulted in presentation to a hospital or emergency department				

Patient has been assessed to be at significant risk of anaphylaxis by a relevant practitioner

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:					
Bee venom						
INITIATION           Prerequisites (tick boxes where appropriate)						
ARST or skin test positive						
O Patient has had severe generalised reaction to the sensiti	sing agent					

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.

PRES	SCRIBER		PATIENT:
Name	):		Name:
Ward:			NHI:
Раре	er wasp	venom	
INITIATION           Prerequisites (tick boxes where appropriate)		(tick boxes where appropriate)	
	and	RAST or skin test positive	
		Patient has had severe generalised reaction to the sensitising	agent

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:
Yellow jacket wasp venom	
INITIATION           Prerequisites (tick boxes where appropriate)	
ARAST or skin test positive	
O Patient has had severe generalised reaction to the sensitising	agent

Form	<b>RS1518</b>
July 20	25

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:	

# Long-acting muscarinic antagonists with long-acting beta-adrenoceptor agonists

INITIATION Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)				
O Patient has been stabilised on a long acting muscarinic antagonist and				
O The prescriber considers that the patient would receive additional benefit from switching to a combination product				
CONTINUATION Re-assessment required after 2 years				
Prerequisites (tick boxes where appropriate)				
O Patient is compliant with the medication and				
O Patient has experienced improved COPD symptom control (prescriber determined)				

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:

# Fluticasone furoate with umeclidinium and vilanterol

# 

Ind			
	O Patient is currently receiving an inhaled corticosteroid with long acting beta-2 agonist (ICS/LABA) or a long acting muscarinic antagonist with long acting beta-2 agonist (LAMA/LABA)		
	a	Clinical criteria:	
		O Patient has a COPD Assessment Test (CAT) score greater than 10	
		or O Patient has had 2 or more exacerbations in the previous 12 months	
		O Patient has had one exacerbation requiring hospitalisation in the previous 12 months	
		or O Patient has had an eosinophil count greater than or equal to 0.3 × 10°9 cells/L in the previous 12 months	
or			

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:	

# Budesonide with glycopyrronium and eformoterol

# 

Ind		
	O Patient is currently receiving an inhaled corticosteroid with long acting beta-2 agonist (ICS/LABA) or a long acting muscarinic antagonist with long acting beta-2 agonist (LAMA/LABA)	
	and	Clinical criteria:
		O Patient has a COPD Assessment Test (CAT) score greater than 10
		or O Patient has had 2 or more exacerbations in the previous 12 months or
		O Patient has had one exacerbation requiring hospitalisation in the previous 12 months or
		O Patient has had an eosinophil count greater than or equal to 0.3 × 10 <sup>^</sup> 9 cells/L in the previous 12 months
or		

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:

# Pirfenidone

INITIATION - idiopathic pulmonary fibrosis         Re-assessment required after 12 months         Prerequisites (tick boxes where appropriate)         Image: the preservibed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.         and         Image: the preservibed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.         and       Patient has been diagnosed with idiopathic pulmonary fibrosis by a multidisciplinary team including a radiologist         and       Pirfenidone is to be discontinued at disease progression (See Notes)         and       Pirfenidone is not to be used in combination with subsidised nintedanib         or       Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance         or       Patient has previously received nintedanib, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with nintedanib)         CONTINUATION - idiopathic pulmonary fibrosis         Re-assessment required after 12 months         Prerequisite (ick boxes where appropriate)         or       Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.         and       Prescribed by, or recommended by a resp					
Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.     Patient has been diagnosed with idiopathic pulmonary fibrosis by a multidisciplinary team including a radiologist     Proceed vital capacity is between 50% and 90% predicted     Pirfenidone is to be discontinued at disease progression (See Notes)     Pirfenidone is not to be used in combination with subsidised nintedanib     or     Patient has previously received nintedanib, but discontinued nintedanib     or     Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance     or     Patient has previously received nintedanib, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with nintedanib)	Re-assessment required after 12 months				
NZ Hospital. And Patient has been diagnosed with idiopathic pulmonary fibrosis by a multidisciplinary team including a radiologist and Proceed vital capacity is between 50% and 90% predicted and Pirfenidone is to be discontinued at disease progression (See Notes) and Pirfenidone is not to be used in combination with subsidised nintedanib and Pirfenidone is not to be used in combination with subsidised nintedanib and Patient has previously received treatment with nintedanib or Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance or Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance or Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance or Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance or Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance or Patient has previously received nintedanib, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with nintedanib) CONTINUATION – idiopathic pulmonary fibrosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and Pirfenidone is not to be used in combination with subsidised nintedanib and Pirfenidone is not to be used in combination with subsidised nintedanib	Prerequisites (tick boxes where appropriate)				
and Forced vital capacity is between 50% and 90% predicted and Pirfenidone is to be discontinued at disease progression (See Notes) and Pirfenidone is not to be used in combination with subsidised nintedanib and Pirfenidone is not to be used in combination with subsidised nintedanib or Patient has not previously received treatment with nintedanib or Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance or Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance or Patient has previously received nintedanib, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with nintedanib) CONTINUATION - idiopathic pulmonary fibrosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and Pirfenidone is not to be used in combination with subsidised nintedanib	NZ Hospital.				
CONTINUATION - idiopathic pulmonary fibrosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.					
and Pirfenidone is not to be used in combination with subsidised nintedanib and Or Or Patient has not previously received treatment with nintedanib or Or Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance or Or Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance or Or Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance or Patient has previously received nintedanib, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with nintedanib) <b>CONTINUATION – idiopathic pulmonary fibrosis</b> Re-assessment required after 12 months <b>Prerequisites</b> (tick boxes where appropriate) Or Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and Or Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment and Or Pirfenidone is not to be used in combination with subsidised nintedanib	O Forced vital capacity is between 50% and 90% predicted				
and O The patient has not previously received treatment with nintedanib or O Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance or O Patient has previously received nintedanib, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with nintedanib) CONTINUATION – idiopathic pulmonary fibrosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment and O Pirfenidone is not to be used in combination with subsidised nintedanib					
<ul> <li>or Or Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance</li> <li>or Or Patient has previously received nintedanib, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with nintedanib)</li> <li>CONTINUATION - idiopathic pulmonary fibrosis</li> <li>Re-assessment required after 12 months</li> <li>Prerequisites (tick boxes where appropriate)</li> <li>Or Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.</li> <li>and Or Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment</li> <li>and Or Pirfenidone is not to be used in combination with subsidised nintedanib</li> </ul>					
<ul> <li>Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance</li> <li>Patient has previously received nintedanib, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with nintedanib)</li> <li>CONTINUATION - idiopathic pulmonary fibrosis</li> <li>Re-assessment required after 12 months</li> <li>Prerequisites (tick boxes where appropriate)</li> <li>Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.</li> <li>and</li> <li>Pirfenidone is not to be used in combination with subsidised nintedanib</li> </ul>					
or more decline in predicted FVC within any 12 month period since starting treatment with nintedanib)         CONTINUATION - idiopathic pulmonary fibrosis         Re-assessment required after 12 months         Prerequisites (tick boxes where appropriate)         O       Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.         and       O         Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment         and       O         Pirfenidone is not to be used in combination with subsidised nintedanib	O Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance				
Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment and O Pirfenidone is not to be used in combination with subsidised nintedanib and O D D D D D D D D D D D D D D D D D D					
Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment and O Pirfenidone is not to be used in combination with subsidised nintedanib and O D D D D D D D D D D D D D D D D D D					
Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment and Pirfenidone is not to be used in combination with subsidised nintedanib					
and NZ Hospital.	Prerequisites (tick boxes where appropriate)				
and O Pirfenidone is not to be used in combination with subsidised nintedanib and O	NZ Hospital.				
O Pirfenidone is not to be used in combination with subsidised nintedanib and					
O Pirfenidone is to be discontinued at disease progression (See Note)	O Pirfenidone is not to be used in combination with subsidised nintedanib				
	O Pirfenidone is to be discontinued at disease progression (See Note)				

Note: disease progression is defined as a decline in percent predicted FVC of 10% or more within any 12 month period.

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:

# Nintedanib

Re-a	INITIATION – idiopathic pulmonary fibrosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)				
( and	O Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed NZ Hospital.				
	( and	O Patient has been diagnosed with idiopathic pulmonary fibrosis by a multidisciplinary team including a radiologist			
	( and	O Forced vital capacity is between 50% and 90% predicted			
	( and	$\sim$			
	and				
		O The patient has not previously received treatment with pirfenidone or			
		<ul> <li>Patient has previously received pirfenidone, but discontinued pirfenidone within 12 weeks due to intolerance</li> <li>Or</li> <li>Patient has previously received pirfenidone, but the patient's disease has not progressed (disease progression defined as 10%)</li> </ul>			
		or more decline in predicted FVC within any 12 month period since starting treatment with pirfenidone)			
Re-a	ssess	ATION – idiopathic pulmonary fibrosis sment required after 12 months sites (tick boxes where appropriate)			
( and		Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
	( and	O Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment			
	( and	O Nintedanib is not to be used in combination with subsidised pirfenidone			
	(	O Nintedanib is to be discontinued at disease progression (See Note)			

Note: disease progression is defined as a decline in percent predicted FVC of 10% or more within any 12 month period.

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				P,	ATIENT:
Name:				N	ame:
Ward:				N	НІ:
lvaca	ftor				
	Эр	<b>tes</b> ( resc	ribed	boxes where appropriate) by, or recommended by a respiratory specialist or paediatric by the Health NZ Hospital.	cian, or in accordance with a protocol or guideline that has been
	( and	С	Patie	ent has been diagnosed with cystic fibrosis	
		or	0	Patient must have G551D mutation in the cystic fibrosis tra 1 allele	nsmembrane conductance regulator (CFTR) gene on at least
			Ο	Patient must have other gating (class III) mutation (G1244E in the CFTR gene on at least 1 allele	E, G1349D, G178R, G551S, S1251N, S1255P, S549N and S549R)
	and (			ents must have a sweat chloride value of at least 60 mmol/L ction system	by quantitative pilocarpine iontophoresis or by Macroduct sweat
	and ( and	С	Treat	tment with ivacaftor must be given concomitantly with standa	ard therapy for this condition
	(			ent must not have an acute upper or lower respiratory infection iotics) for pulmonary disease in the last 4 weeks prior to con	on, pulmonary exacerbation, or changes in therapy (including nmencing treatment with ivacaftor
	and ( and	С	The c	dose of ivacaftor will not exceed one tablet or one sachet twi	ce daily
		С	Appli	icant has experience and expertise in the management of cy	stic fibrosis

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:	

# Elexacaftor with tezacaftor, ivacaftor and ivacaftor

## INITIATION

equisi	ites	(tick b	poxes where appropriate)
( and	С	Patie	ent has been diagnosed with cystic fibrosis
and (	С	Patie	ent is 6 years of age or older
		0	Patient has two cystic fibrosis-causing mutations in the cystic fibrosis transmembrane regulator (CFTR) gene (one from each parental allele)
	or	0	Patient has a sweat chloride value of at least 60 mmol/L by quantitative pilocarpine iontophoresis or by Macroduct sweat collection system
and	_		
		Ο	Patient has a heterozygous or homozygous F508del mutation
	or	Ο	Patient has a G551D mutation or other mutation responsive in vitro to elexacaftor/tezacaftor/ivacaftor (see note a)
and (	С	The	treatment must be the sole funded CFTR modulator therapy for this condition
and (	С	Treat	ment with elexacaftor/tezacaftor/ivacaftor must be given concomitantly with standard therapy for this condition
:			
			s are listed in the Food and Drug Administration (FDA) Trikafta prescribing information a.gov/fdalabel/services/spl/set-ids/f354423a-85c2-41c3-a9db-0f3aee135d8d/spl-doc

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:

# Dornase alfa

INITIATION – cystic fibrosis Re-assessment required after 12 months			
Prerequisites (tick boxes where appropriate)			
O Prescribed by, or recommended by a respiratory physician or paediatrician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
O Patient has a confirmed diagnosis of cystic fibrosis			
O Patient has previously undergone a trial with, or is currently being treated with, hypertonic saline and			
O Patient has required one or more hospital inpatient respiratory admissions in the previous 12 month period or			
O Patient has had 3 exacerbations due to CF, requiring oral or intravenous (IV) antibiotics in in the previous 12 month period or			
O Patient has had 1 exacerbation due to CF, requiring oral or IV antibiotics in the previous 12 month period and a Brasfield score of < 22/25			
O Patient has a diagnosis of allergic bronchopulmonary aspergillosis (ABPA)			
CONTINUATION – cystic fibrosis         Prerequisites (tick box where appropriate)         O       Prescribed by, or recommended by a respiratory physician or paediatrician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.         and       O         The treatment remains appropriate and the patient continues to benefit from treatment			
INITIATION – significant mucus production Re-assessment required after 4 weeks Prerequisites (tick boxes where appropriate)			
Patient is an in-patient and The mucus production cannot be cleared by first line chest techniques			
INITIATION – pleural emphyema Re-assessment required after 3 days Prerequisites (tick boxes where appropriate)			
O Patient is an in-patient and _			
O Patient diagnoses with pleural emphyema			

Sensory Organs

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:

## Dexamethasone

	ATIO	N – I	Diabetic macular oedema		
Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)					
FIEle	quis	nes	(lick boxes where appropriate)		
( and		Preso Hosp	cribed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.		
	and	0	Patients have diabetic macular oedema with pseudophakic lens		
	and	0	Patient has reduced visual acuity of between 6/9 – 6/48 with functional awareness of reduction in vision		
		or	O Patient's disease has progressed despite 3 injections with bevacizumab		
			O Patient is unsuitable or contraindicated to treatment with anti-VEGF agents		
	and	0	Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year		
Re-as	sess	mer	DN – Diabetic macular oedema t required after 12 months (tick boxes where appropriate)		
and		Preso Hosp	cribed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.		
	and	0	Patient's vision is stable or has improved (prescriber determined)		
		0	Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year		
			Nomen of child bearing age with diabetic macular oedema t required after 12 months		
			(tick boxes where appropriate)		
and		Preso Hosp	cribed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.		
	and	0	Patients have diabetic macular oedema		
	and and	0	Patient has reduced visual acuity of between 6/9 – 6/48 with functional awareness of reduction in vision		
	and	0	Patient is of child bearing potential and has not yet completed a family		
		0	Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year		

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.

PRES	CRIBER		PATIENT:	
Name	:		Name:	
Ward:			NHI:	
Dexa	metha	sone - continued		
Re-a	ssessme equisites		dema ance with a protocol or guideline that has been endorsed by the Health NZ	
	Patient's vision is stable or has improved (prescriber determined)     and     Patient is of child bearing potential and has not yet completed a family     and     Dexamethasone implants are to be administered not more frequently than once every 4 m     of 3 implants per eye per year			a family

Various

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:	

# Deferasirox

Re-a	INITIATION Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)					
and	Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.					
	and	<ul> <li>The patient has been diagnosed with chronic iron overload due to congenital inherited anaemia</li> <li>Deferasirox is to be given at a daily dose not exceeding 40 mg/kg/day</li> </ul>				
		<ul> <li>O Treatment with maximum tolerated doses of deferiprone monotherapy or deferiprone and desferrioxamine combination therapy have proven ineffective as measured by serum ferritin levels, liver or cardiac MRI T2*</li> <li>O Treatment with deferiprone has resulted in severe persistent vomiting or diarrhoea</li> <li>O Treatment with deferiprone has resulted in arthritis</li> <li>O Treatment with deferiprone is contraindicated due to a history of agranulocytosis (defined as an absolute neutrophil count (ANC) of &lt; 0.5 cells per μL) or recurrent episodes (greater than 2 episodes) of moderate neutropenia (ANC 0.5 - 1.0 cells per μL)</li> </ul>				
Re-a	isses equi:	ATION ment required after 2 years ites (tick boxes where appropriate)				
and	<ul> <li>Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.</li> <li>and</li> </ul>					
	or	<ul> <li>For the first renewal following 2 years of therapy, the treatment has been tolerated and has resulted in clinical improvement in all three parameters namely serum ferritin, cardiac MRI T2* and liver MRI T2* levels</li> <li>For subsequent renewals, the treatment has been tolerated and has resulted in clinical stability or continued improvement in all three parameters namely serum ferritin, cardiac MRI T2* and liver MRI T2* levels</li> </ul>				

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:
Deferiprone	
INITIATION	

Prerequisites (tick box where appropriate)

O Patient has been diagnosed with chronic iron overload due to congenital inherited anaemia or acquired red cell aplasia

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:		
Povidone-iodine - Vaginal tab 200 mg			
INITIATION			
Prerequisites (tick box where appropriate)			
O Rectal administration pre-prostate biopsy			

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:
Chlorhexidine with cetrimide	
INITIATION         Re-assessment required after 3 months         Prerequisites (tick boxes where appropriate)         O         Patient has burns that are greater than 30% of total body surface         and         O         For use in the perioperative preparation and cleansing of large         and         O         The use of 30 ml ampoules is impractical due to the size of th	e burn areas requiring debridement/skin grafting

Re-assessment required after 3 months Prerequisites (tick box where appropriate)

O The treatment remains appropriate for the patient and the patient is benefiting from the treatment

Special Foods

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:

## Carbohydrate

	INITIATION – Use as an additive Prerequisites (tick boxes where appropriate)				
or	0	Cystic fibrosis			
or	Ο	Chronic kidney disease			
or	Ο	Cancer in children			
or	Ο	Cancers affecting alimentary tract where there are malabsorption problems in patients over the age of 20 years			
or	Ο	Faltering growth in an infant/child			
or	Ο	Bronchopulmonary dysplasia			
or	$\bigcirc$	Premature and post premature infant			
or	$\bigcirc$				
		Inborn errors of metabolism			
		Use as a module			

**Prerequisites** (tick box where appropriate)

O For use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

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.

PRES	SCRI	BER		PATIENT:
Name	:			Name:
Ward				NHI:
Fat				
			Use as an additive (tick boxes where appropriate)	
		0	Patient has inborn errors of metabolism	
	or	Ο	Faltering growth in an infant/child	
	or	Ο	Bronchopulmonary dysplasia	
	or	Ο	Fat malabsorption	
	or	Ο	Lymphangiectasia	
	or or	Ο	Short bowel syndrome	
		Ο	Infants with necrotising enterocolitis	
	or	Ο	Biliary atresia	
	or	Ο	For use in a ketogenic diet	
	or	Ο	Chyle leak	
	or	Ο	Ascites	
	or	Ο	Patient has increased energy requirements, and for whom	dietary measures have not been successful

#### **INITIATION – Use as a module**

Prerequisites (tick box where appropriate)

O For use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk. Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

Signed Date
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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:
Protein	
INITIATION – Use as an additive           Prerequisites (tick boxes where appropriate)	
or O High protein needs	
NITIATION – Use as a module	

Prerequisites (tick box where appropriate)

O For use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk. Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

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:	
Carbohydrate and fat sunnlement		

## arbohydrate and fat supplement

( and	С	Infar	ant or child aged four years or under	
		Ο	Cystic fibrosis	
	or	Ο	Cancer in children	
	or	Ο	D Faltering growth	
	or	Ο	D Bronchopulmonary dysplasia	
	or	Ο	Premature and post premature infants	

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.

PRES	CR	IBER	PATIENT:
Name	:		Name:
Ward:			NHI:
Meta	bo	lic Products	
INITI Prere		ON isites (tick boxes where appropriate)	
		O For the dietary management of inherited metabolic disease	
	or	O Patient has adrenoleukodystrophy	

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.

PRESCF	RIBER	PATIENT:
Name: .		Name:
Ward:		NHI:

# **Diabetic Products**

INITI Prere			(tick boxes where appropriate)
		Ο	For patients with type I or type II diabetes suffering weight loss and malnutrition that requires nutritional support
	or	Ο	For patients with pancreatic insufficiency
	or	Ο	For patients who have, or are expected to, eat little or nothing for 5 days
	or	Ο	For patients who have a poor absorptive capacity and/or high nutrient losses and/or increased nutritional needs from causes such as catabolism
	or	0	For use pre- and post-surgery
	or	Ο	For patients being tube-fed
	or	0	For tube-feeding as a transition from intravenous nutrition

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:	
Elemental and Semi-Elemental Products		

INITI. Prere			(tick boxes where appropriate)	
		0	Malabsorption	
	or	Ο	Short bowel syndrome	
	or	Ο	Enterocutaneous fistulas	
	or	Ο	Eosinophilic enteritis (including oesophagitis)	
	or	Ο	Inflammatory bowel disease	
	or	Ο	Acute pancreatitis where standard feeds are not tolerated	
	or	Ο	Patients with multiple food allergies requiring enteral feeding	

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:
Fat-modified feed		
INITIATION Prerequisites (tick boxes where appropriate) O Patient has metabolic disorder or O Patient has a chyle leak or Modified as a modular feed, r Pharmaceutical Schedule, for	ers of fat metabolism nade from at least one nutrient me	odule and at least one further product listed in Section D of the

Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

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:
Hepatic Products	
INITIATION Prerequisites (tick box where appropriate)	
O For children (up to 18 years) who require a liver transplant	

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:
High Calaria Braduata	

## **High Calorie Products**

ATIO equis		k boxes where appropriate)
	O	tient is fluid volume or rate restricted
or or	0	tient requires low electrolyte
	and	O       Cystic fibrosis         O       Any condition causing malabsorption         Or       O         Faltering growth in an infant/child         O       Increased nutritional requirements
		Patient has substantially increased metabolic requirements

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.

PRE	SCRIB	ER			PATIENT:
Name	ə:				Name:
Ward	:				NHI:
High	n pro	tein	ent	eral feed	
	IATIOI requisi	ites		poxes where appropriate)	
	and		The	patient has a high protein requirement	
		or	Ο	Patient has liver disease	
			Ο	Patient is obese (BMI > 30) and is undergoing surgery	
		or or	Ο	Patient is fluid restricted	

O Patient's needs cannot be more appropriately met using high calorie product

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:	

# Extensively hydrolysed formula

## INITIATION Prerequisites (tick boxes where appropriate) Cows' milk formula is inappropriate due to severe intolerance or allergy to its protein content and Soy milk formula has been reasonably trialled without resolution of symptoms or Soy milk formula is considered clinically inappropriate or contraindicated or ( ) Severe malabsorption or Short bowel syndrome or Intractable diarrhoea or Biliary atresia or Cholestatic liver diseases causing malsorption or Cystic fibrosis or ( ) Proven fat malabsorption or Severe intestinal motility disorders causing significant malabsorption or ( )Intestinal failure or For step down from Amino Acid Formula Note: A reasonable trial is defined as a 2-4 week trial, or signs of an immediate IgE mediated allergic reaction. CONTINUATION

Prerequisites (tick boxes where appropriate)

 $\bigcirc$ 

and

An assessment as to whether the infant can be transitioned to a cows' milk protein or soy infant formula has been undertaken

The outcome of the assessment is that the infant continues to require an extensively hydrolysed infant formula

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:
Preterm formula	
INITIATION Prerequisites (tick box where appropriate)	
O For infants born before 33 weeks' gestation or weighing less than 1.	5 kg at birth

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:		
Paediatric oral/enteral feed 1 kcal/ml			
INITIATION – Fluid restricted or volume intolerance with faltering growth			

Prerequisites (tick boxes where appropriate)

or

and

The patient is fluid restricted or volume intolerant

The patient has increased nutritional requirements due to faltering growth ( )

) Patient is under 18 months old and weighs less than 8kg

Note: 'Volume intolerant' patients are those who are unable to tolerate an adequate volume of infant formula to achieve expected growth rate. These patients should have first trialled appropriate clinical alternative treatments, such as concentrating, fortifying and adjusting the frequency of feeding.

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:

## Enteral liquid peptide formula

## INITIATION Prerequisites (tick boxes where appropriate) ( ) Patient has impaired gastrointestinal function and either cannot tolerate polymeric feeds, or polymeric feeds are unsuitable and () Severe malabsorption or Short bowel syndrome or Intractable diarrhoea or Biliary atresia or Cholestatic liver diseases causing malabsorption or Cystic fibrosis or Proven fat malabsorption or Severe intestinal motility disorders causing significant malabsorption or Intestinal failure or O The patient is currently receiving funded amino acid formula and The patient is to be trialled on, or transitioned to, an enteral liquid peptide formula and ( ) A semi-elemental or partially hydrolysed powdered feed has been reasonably trialled and considered unsuitable or For step down from intravenous nutrition Note: A reasonable trial is defined as a 2-4 week trial. CONTINUATION Prerequisites (tick boxes where appropriate) An assessment as to whether the patient can be transitioned to a cows milk protein or soy infant formula or extensively hydrolysed formula has been undertaken and

The outcome of the assessment is that the patient continues to require an enteral liquid peptide formula

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:	Name:	
Ward:	NHI:	

# Amino acid formula

# INITIATION Prerequisites (tick boxes where appropriate) C Extensively hydrolysed formula has been reasonably trialled for 2-4 weeks and is inappropriate due to documented severe intolerance or allergy or malabsorption or C History of anaphylaxis to cows' milk protein formula or dairy products or C Eosinophilic oesophagitis or C Ultra-short gut or C Severe Immune deficiency

## CONTINUATION

and

and

and

and

Prerequisites	(tick boxes	where	appropriate)	)
---------------	-------------	-------	--------------	---

An assessment as to whether the infant can be transitioned to a cows' milk protein, soy, or extensively hydrolysed infant formula has been undertaken
 The outcome of the assessment is that the infant continues to require an amino acid infant formula

 $\bigcirc$  Amino acid formula is required for a nutritional deficit

#### INITIATION – patients who are currently funded under RS1502 or SA1557

Re-assessment required after 3 months **Prerequisites** (tick boxes where appropriate)

Patient has a valid initiation or renewal approval for extensively hydrolysed formula (RS1502)

Patient is unable to source funded Aptamil powder at this time

The approval only applies to funded dispensings of Neocate Gold and Neocate Syneo

Note: This criteria is short term funding to cover an out-of-stock situation on some extensively hydrolysed formula powder funded under Hospital Restriction RS1502. There is no continuation criteria under this criterion.

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:	Name:	
Ward:	NHI:	
High fat formula		

## INITIATION

Prerequisites (tick box where appropriate)

()For patients with intractable epilepsy, pyruvate dehydrogenase deficiency or glucose transported type-1 deficiency and other conditions requiring a ketogenic diet

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:	
Ward:	NHI:	

### **Paediatric Products**

IITIATI rerequ		s (tick b	poxes where appropriate)
an	O d	Child	d is aged one to ten years
	ο	0	The child is being fed via a tube or a tube is to be inserted for the purposes of feeding
		Ο	Any condition causing malabsorption
	0	Ο	Faltering growth in an infant/child
	0	$\bigcirc$	Increased nutritional requirements
	0	$\bigcirc$	The child is being transitioned from TPN or tube feeding to oral feeding
	0	Ó	The child has eaten, or is expected to eat, little or nothing for 3 days

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:
Low electrolyte oral feed	
INITIATION           Prerequisites (tick box where appropriate)	
O For children (up to 18 years) with acute or chronic kidney disease	

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:
Low electrolyte oral feed	
INITIATION Prerequisites (tick box where appropriate)	
O For patients with acute or chronic kidney disease	

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:
Preoperative carbohydrate feed 0.5 kcal/ml	

#### INITIATION

Prerequisites (tick box where appropriate)

O Maximum of 400 ml as part of an Enhanced Recovery After Surgery (ERAS) protocol 2 to 3 hours before major abdominal surgery

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:
High arginine oral feed 1.4 kcal/ml	
INITIATION           Prerequisites (tick box where appropriate)	
m O Three packs per day for 5 to 7 days prior to major gastrointestinal, h	ead or neck surgery

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:
Standard Feeds	

For	patients with malnutrition, defined as any of the following:
	O BMI < 18.5
0	O Greater than 10% weight loss in the last 3-6 months
0	O BMI < 20 with greater than 5% weight loss in the last 3-6 months
or	
Ο	For patients who have, or are expected to, eat little or nothing for 5 days
or O	For patients who have, or are expected to, eat little or nothing for 5 days For patients who have a poor absorptive capacity and/or high nutrient losses and/or increased nutritional needs from causes such as catabolism
Ο	For patients who have a poor absorptive capacity and/or high nutrient losses and/or increased nutritional needs from causes such as catabolism
or O	For patients who have a poor absorptive capacity and/or high nutrient losses and/or increased nutritional needs from causes such as
or () or ()	For patients who have a poor absorptive capacity and/or high nutrient losses and/or increased nutritional needs from causes such as catabolism
or () or ()	For patients who have a poor absorptive capacity and/or high nutrient losses and/or increased nutritional needs from causes such as catabolism For use pre- and post-surgery

Vaccines

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:		

### Diphtheria, tetanus, pertussis and polio vaccine

	Ο	A single dose for children up to the age of 7 who have completed primary immunisation
or or	0	A course of up to four vaccines is funded for catch up programmes for children (to the age of 10 years) to complete full primary immunisation
01	Ο	An additional four doses (as appropriate) are funded for (re-)immunisation for patients post HSCT, or chemotherapy; pre- or post splenectomy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens
or	0	Five doses will be funded for children requiring solid organ transplantation

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:

### Diphtheria, tetanus, pertussis, polio, hepatitis B and haemophilus influenzae type B vaccine

INITIATION Prerequisites (tick boxes where appropriate)				
		0	Up to four doses for children under the age of 10 years for primary immunisation	
	or	0	An additional four doses (as appropriate) for (re-)immunisation of children under the age of 18 years post haematopoietic stem cell transplantation	
	or	Ο	An additional four doses (as appropriate) for (re-)immunisation of children under the age of 10 years who are post chemotherapy; pre or post splenectomy; undergoing renal dialysis and other severely immunosuppressive regimens	
	or	0	Up to five doses for children under the age of 10 years receiving solid organ transplantation	

Note: A course of up-to four vaccines is funded for catch up programmes for children (up to and under the age of 10 years) to complete full primary immunisation. Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes.

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:	
Bacillus calmette-guerin vaccine		
<b>INITIATION</b> <b>Prerequisites</b> (tick boxes where appropriate)		
For infants at increased risk of tuberculosis defined as:		
O Living in a house or family with a person with current or past history of TB		
And O Having one or more household members or carers who within the last 5 years lived in a country with a rate of TB > or equal to 40 per 100,000 for 6 months or longer		
and During their first 5 years will be living 3 months or longer in a d	country with a rate of TB $>$ or equal to 40 per 100 000	

Note: A list of countries with high rates of TB are available at http://www.health.govt.nz/tuberculosis (Search for Downloads) or www.bcgatlas.org/index.php

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:	

#### Diphtheria, tetanus and pertussis vaccine

#### INITIATION Prerequisites (tick boxes where appropriate) ( ) A single dose for pregnant women in the second or third trimester of each pregnancy; or or A single dose for parents or primary caregivers of infants admitted to a Neonatal Intensive Care Unit or Specialist Care Baby Unit for more than 3 days, who had not been exposed to maternal vaccination at least 14 days prior to birth; or or A course of up to four doses is funded for children from age 7 up the age of 18 years inclusive to complete full primary immunisation or An additional four doses (as appropriate) are funded for (re-)immunisation for patients post haematopoietic stem cell transplantation or chemotherapy; pre or post splenectomy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens or A single dose for vaccination of patients aged from 65 years old or A single dose for vaccination of patients aged from 45 years old who have not had 4 previous tetanus doses or For vaccination of previously unimmunised or partially immunised patients or For revaccination following immunosuppression or For boosting of patients with tetanus-prone wounds

Note: Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes.

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.

PRES	SCRI	BER		PATIENT:
Name	e:			Name:
Ward				NHI:
Haer	nop	ohilu	s influenzae type B vaccine	
	sses	smen	t required after 1 dose (tick boxes where appropriate)	
	~	Ο	For primary vaccination in children	
	<ul> <li>An additional dose (as appropriate) is funded for (re-)immunisation for patients post haematopoietic stem cell transplantation, or chemotherapy; functional asplenic; pre or post splenectomy; pre- or post solid organ transplant, pre- or post cochlear implants, renal dialysis and other severely immunosuppressive regimens</li> </ul>			
		0	For use in testing for primary immunodeficiency diseases, on t	he recommendation of an internal medicine physician or paediatrician

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:	

### Meningococcal (A, C, Y and W-135) conjugate vaccine

#### INITIATION Prerequisites (tick boxes where appropriate) () Up to three doses and a booster every five years for patients pre- and post splenectomy and for patients with HIV, complement deficiency (acquired or inherited), functional or anatomic asplenia or pre or post solid organ transplant or One dose for close contacts of meningococcal cases of any group or One dose for person who has previously had meningococcal disease of any group or A maximum of two doses for bone marrow transplant patients or A maximum of two doses for person pre and post-immunosuppression\* or () Person is aged between 13 and 25 years, inclusive and $\bigcirc$ One dose for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, or prisons or ()One dose for individuals who turn 13 years of age while living in boarding school hostels

Note: children under seven years of age require two doses 8 weeks apart, a booster dose three years after the primary series and then five yearly. \*Immunosuppression due to steroid or other immunosuppressive therapy must be for a period of greater than 28 days.

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:	

### Meningococcal (A, C, Y and W-135) conjugate vaccine

Note: infants from 6 weeks to less than 6 months of age require a 2+1 schedule, infants from 6 months to less than 12 months of age require a 1+1 schedule. Refer to the Immunisation Handbook for recommended booster schedules with meningococcal ACWY vaccine. \*Immunosuppression due to steroid or other immunosuppressive therapy must be for a period of greater than 28 days.

Use this checklist to determine if a patient meets the restrictions for funding in the <b>h</b> Schedule. For community funding, see the Special Authority Criteria.	<b>spital setting</b> . For more details, refer to Section H of the Pharmaceutical
PRESCRIBER PA	FIENT:
Name: Na	ne:
Ward: NH	l:
Pneumococcal (PCV13) conjugate vaccine	
INITIATION – Primary course for previously unvaccinated children aged und         Re-assessment required after 3 doses         Prerequisites (tick box where appropriate)         O       A primary course of three doses for previously unvaccinated children up	
INITIATION – High risk individuals who have received PCV10         Re-assessment required after 2 doses         Prerequisites (tick box where appropriate)         O       Two doses are funded for high risk individuals (over the age of 12 month primary course of PCV10	s and under 18 years) who have previously received two doses of the
INITIATION – High risk children aged under 5 years         Re-assessment required after 4 doses         Prerequisites (tick boxes where appropriate)         O       Up to an additional four doses (as appropriate) are funded for the and	re)immunisation of high-risk children aged under 5 years
<ul> <li>On immunosuppressive therapy or radiation therapy, vaccination</li> <li>Primary immune deficiencies</li> <li>Primary immune deficiencies</li> <li>HIV infection</li> <li>Renal failure, or nephrotic syndrome</li> <li>Reriand failure, or nephrotic syndrome</li> <li>Are immune-suppressed following organ transplantation (incomposed for Cochlear implants or intracranial shunts</li> <li>Cerebrospinal fluid leaks</li> </ul>	nd who are on an equivalent daily dosage of prednisone of 2 mg/kg n a total daily dosage of 20 mg or greater

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:	
	Nalle.	
Ward:		
Pneumococcal (PCV13) conjugate vaccine - continued		
INITIATION – High risk individuals 5 years and over Re-assessment required after 4 doses Prerequisites (tick box where appropriate)		
O Up to an additional four doses (as appropriate) are funded for the (re-)immunisation of individuals 5 years and over with HIV, pre or post haematopoietic stem cell transplantation, or chemotherapy; pre- or post splenectomy; functional asplenia, pre- or post- solid organ transplant, renal dialysis, complement deficiency (acquired or inherited), cochlear implants, intracranial shunts, cerebrospinal fluid leaks or primary immunodeficiency		
INITIATION – Testing for primary immunodeficiency diseases Prerequisites (tick box where appropriate)		
O For use in testing for primary immunodeficiency diseases, on the red	commendation of an internal medicine physician or paediatrician	
Note: Please refer to the Immunisation Handbook for the appropriate schedu	le for catch up programmes	

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.	

PRESCRIBE	R	PATIENT:	
Name:	Name:		
Ward:	Ward: NHI:		
Pneumoco	occal	(PPV23) polysaccharide vaccine	
Re-assessm Prerequisite O Fo as	ent rec es (tick r patie plenia,	n risk patients quired after 3 doses < box where appropriate) nts with HIV, for patients post haematopoietic stem cell transplant, or chemotherapy; pre- or post-splenectomy; or with functional , pre- or post-solid organ transplant, renal dialysis, complement deficiency (acquired or inherited), cochlear implants, or primary deficiency	
Re-assessm	ent ree	n risk children quired after 2 doses < boxes where appropriate)	
and	) Pat	tient is a child under 18 years for (re-)immunisation	
	С	On immunosuppressive therapy or radiation therapy, vaccinate when there is expected to be a sufficient immune response	
	or C	With primary immune deficiencies	
	O With HIV infection		
	or O With renal failure, or nephrotic syndrome		
	or O Who are immune-suppressed following organ transplantation (including haematopoietic stem cell transplant)		
	or O With cochlear implants or intracranial shunts		
	or O With cerebrospinal fluid leaks		
	or C or	Receiving corticosteroid therapy for more than two weeks, and who are on an equivalent daily dosage of prednisone of 2 mg/kg per day or greater, or children who weigh more than 10 kg on a total daily dosage of 20 mg or greater	
	O With chronic pulmonary disease (including asthma treated with high-dose corticosteroid therapy)		
	O Pre term infants, born before 28 weeks gestation		
	or C	With cardiac disease, with cyanosis or failure	
	or C	With diabetes	
	or C	With Down syndrome	
	or C	Who are pre-or post-splenectomy, or with functional asplenia	

#### INITIATION – Testing for primary immunodeficiency diseases Prerequisites (tick box where appropriate)

O For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician

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:
Salmonella typhi vaccine	
INITIATION Prerequisites (tick box where appropriate)	
${ m O}~$ For use during typhoid fever outbreaks	

and

or

#### 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.	

RESCRIBE	3	PATIENT:
lame:		Name:
Vard:		NHI:
leningoc	occal B multicomponent vaccine	
	- Primary immunisation for children up to 12 months of age ent required after 3 doses	9
	s (tick boxes where appropriate)	
or	Three doses for children up to 12 months of age (inclusive) f	or primary immunisation
	Up to three doses (dependent on age at first dose) for a cate (inclusive) for primary immunisation, from 1 March 2023 to 3	ch-up programme for children from 13 months to 59 months of age 1 August 2025
		pre- and post-splenectomy and for patients with functional or anatomic
or C	<ul><li>asplenia, HIV, complement deficiency (acquired or inherited)</li><li>Up to two doses for close contacts of meningococcal cases of the splene of the</li></ul>	
or or	Up to two doses for person who has previously had meningo	pecoccal disease of any group
or	Up to two doses for bone marrow transplant patients	
C	Up to two doses for person pre- and post-immunosuppression	on*
	Person is and between 12 and 25 years (inclusive)	
Re-assessm	<ul> <li>Person is aged between 13 and 25 years (inclusive)</li> <li>ent required after 2 doses</li> <li>s (tick boxes where appropriate)</li> </ul>	
C	Person is aged between 13 and 25 years (inclusive)	

O Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons

O Two doses for individuals who turn 13 years of age while living in boarding school hostels

Note: \*Immunosuppression due to corticosteroid or other immunosuppressive therapy must be for a period of greater than 28 days.

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.

PRES	SCRI	BER		PATIENT:
Name	:			Name:
Ward:				NHI:
Нера	atiti	s A v	vaccine	
INITI Prere			(tick boxes where appropriate)	
	_	0	Two vaccinations for use in transplant patients	
	or	Ο	Two vaccinations for use in children with chronic liver disease	
	or	0	One dose of vaccine for close contacts of known hepatitis A ca	ases

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:

### Hepatitis B recombinant vaccine

#### INITIATION Prerequisites (tick boxes where appropriate) ( ) For household or sexual contacts of known acute hepatitis B patients or hepatitis B carriers or For children born to mothers who are hepatitis B surface antigen (HBsAg) positive or For children up to and under the age of 18 years inclusive who are considered not to have achieved a positive serology and require additional vaccination or require a primary course of vaccination or ()For HIV positive patients or For hepatitis C positive patients or For patients following non-consensual sexual intercourse or For patients prior to planned immunosuppression for greater than 28 days or ( ) For patients following immunosuppression or For solid organ transplant patients or For post-haematopoietic stem cell transplant (HSCT) patients or Following needle stick injury or For dialysis patients or For liver or kidney transplant patients

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:		

### Hepatitis B recombinant vaccine

#### INITIATION Prerequisites (tick boxes where appropriate) ( ) For household or sexual contacts of known acute hepatitis B patients or hepatitis B carriers or For children born to mothers who are hepatitis B surface antigen (HBsAg) positive or For children up to and under the age of 18 years inclusive who are considered not to have achieved a positive serology and require additional vaccination or require a primary course of vaccination or ()For HIV positive patients or For hepatitis C positive patients or For patients following non-consensual sexual intercourse or For patients prior to planned immunosuppression for greater than 28 days or ( ) For patients following immunosuppression or For solid organ transplant patients or For post-haematopoietic stem cell transplant (HSCT) patients or Following needle stick injury

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.

PRESCR	IBER	PATIENT:			
Name: .		Name:			
Ward:		NHI:			
Influen	za vaccine Inj 60 mcg in 0.5 ml syringe (quadrivalen	t vaccine)			
	INITIATION – People over 65 Prerequisites (tick box where appropriate) O The patient is 65 years of age or over				
	INITIATION – cardiovascular disease Prerequisites (tick boxes where appropriate)				
or	O Congestive heart failure				
or	O Congenital heart disease				
Note: hy	Cerebro-vascular disease     //pertension and/or dyslipidaemia without evidence of end-organ disea	ise is excluded from funding.			

#### **INITIATION – chronic respiratory disease**

 $\bigcirc$ 

or

Prerequisites (tick boxes where appropriate)

Asthma, if on a regular preventative therapy

O Other chronic respiratory disease with impaired lung function

Note: asthma not requiring regular preventative therapy is excluded from funding.

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:		

### Influenza vaccine Inj 60 mcg in 0.5 ml syringe (quadrivalent vaccine) - continued

		Ο	Diabetes
	or	0	Chronic renal disease
	or	0	Any cancer, excluding basal and squamous skin cancers if not invasive
	or	Ο	Autoimmune disease
	or	Ο	Immune suppression or immune deficiency
	or	Ο	HIV
	or	Ο	Transplant recipient
	or	Ο	Neuromuscular and CNS diseases/ disorders
	or	Ο	Haemoglobinopathies
	or	Ο	Is a child on long term aspirin
	or	Ο	Has a cochlear implant
	or or	Ο	Errors of metabolism at risk of major metabolic decompensation
		Ο	Pre and post splenectomy
	or or	Ο	Down syndrome
	or	Ο	Is pregnant
	01	0	Is a child 4 years of age or under (inclusive) who has been hospitalised for respiratory illness or has a history of significant respiratory illness
r (		Patie Hosp	ents in a long-stay inpatient mental health care unit or who are compulsorily detained long-term in a forensic unit within a Publi ital
ION	– S	eriou	us mental health conditions or addiction

 or
 O
 Schizophrenia

 or
 O
 Major depressive disorder

 or
 O
 Bipolar disorder

 or
 O
 Schizoaffective disorder

 or
 O
 Schizoaffective disorder

 or
 O
 Person is currently accessing secondary or tertiary mental health and addiction services

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.

PRES	SCRI	BER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Mea	sles	s, mı	imps and rubella vaccine	
Re-a	sses	smen	<b>irst dose prior to 12 months</b> t required after 3 doses (tick boxes where appropriate)	
	or or	0 0	For primary vaccination in children For revaccination following immunosuppression	
		$\bigcirc$	For any individual susceptible to measles, mumps or rubella	
Re-a	isses	smen	<b>irst dose after 12 months</b> t required after 2 doses (tick boxes where appropriate)	
	or	0 0	For primary vaccination in children For revaccination following immunosuppression	
		0	For any individual susceptible to measles, mumps or rubella	

Note: Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes.

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:	
Poliomyelitis vaccine		
INITIATION         Re-assessment required after 3 doses         Prerequisites (tick boxes where appropriate)         O       For partially vaccinated or previously unvaccinated individuals         or       O         For revaccination following immunosuppression	3	

Note: Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes.

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:
Varicella vacc	ine [Chickenpox vaccine]	
Re-assessment ro Prerequisites (tio	imary vaccinations required after 1 dose ck boxes where appropriate) any infant born on or after 1 April 2016	r after 1 July 2017, who have not previously had a varicella infection
	chickenpox)	a ater 1 duy 2017, who have not previously had a varicella infection
	h <b>er conditions</b> required after 2 doses ck boxes where appropriate)	
fr or or or or ( or (	<ul> <li>or non-immune patients:</li> <li>With chronic liver disease who may in future be candidat</li> <li>With deteriorating renal function before transplantation</li> <li>Prior to solid organ transplant</li> <li>Prior to any elective immunosuppression*</li> <li>For post exposure prophylaxis who are immune competer</li> </ul>	
or or or or or or or or or or or or or	here the household contact has no clinical history of varicella	by, on advice of their specialist moderate immunosuppression on advice of HIV specialist netabolic decompensation, with no clinical history of varicella compromised, or undergoing a procedure leading to immune compromise history of varicella and who are severely immunocompromised or
Note: * immunos	suppression due to steroid or other immunosuppressive thera	py must be for a treatment period of

greater than 28 days

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:	Name:
Ward:	NHI:

### Human papillomavirus (6, 11, 16, 18, 31, 33, 45, 52 and 58) vaccine [HPV]

INITIATION – Children aged 14 years and under Re-assessment required after 2 doses Prerequisites (tick box where appropriate)	
O Children aged 14 years and under	

		O Maximum of three doses for people aged 15 years and over	,
and (	С	The person has recurrent respiratory papillomatosis	
and (	C C	The person has not previously had an HPV vaccine	

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:
Rotavirus oral vaccine	
INITIATION           Re-assessment required after 2 doses	
Prerequisites (tick boxes where appropriate)	
First dose to be administered in infants aged under 14 weeks	of age
No vaccination being administered to children aged 24 weeks	or over

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.

PRES	CRI	BER		PATIENT:	
Name	:			Name:	
Ward:				NHI:	
Varic	ella	a zos	ster vaccine [shingles vaccine]		
Re-as	sses	smen	beople aged 18 years and over (Shingrix) t required after 2 doses (tick boxes where appropriate)		
O Pre- and post-haematopoietic stem cell transplant or cellular therapy					
	or or	Ο	Pre- or post-solid organ transplant		
	or	Ο	Haematological malignancies		
	or	0	People living with poorly controlled HIV infection		
	~ "	0	Planned or receiving disease modifying anti-rheumatic drugs ( polymyalgia rheumatica, systemic lupus erythematosus or rhe	DMARDs – targeted synthetic, biologic, or conventional synthetic) for umatoid arthritis	
	or	Ο	End stage kidney disease (CKD 4 or 5);		
	or	Ο	Primary immunodeficiency		

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:		
COVID-19 vaccine			
INITIATION – initial dose			

Prerequisites (tick box where appropriate)

m O Up to three doses for previously unvaccinated children aged 6 months – 4 years at high risk of severe illness

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.

PRES	SCR	IBER		PATIENT:
Name	e:			Name:
Ward:	:			NHI:
cov	ID-	19 va	accine	
			nitial dose (tick boxes where appropriate)	
		Ο	One dose for previously unvaccinated children aged 5-11 year	s old
	or	0	Up to three doses for immunocompromised children aged 5-11	years old

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:		

### **COVID-19 vaccine**

_

### INITIATION – additional dose

Prerequisites (tick box where appropriate)

O One additional dose every 6 months for people aged 30 years and over, additional dose is given at least 6 months after last dose

#### **CONTINUATION – additional dose**

Prerequisites (tick box where appropriate)

O One additional dose every 6 months for people aged 30 years and over, additional dose is given at least 6 months after last dose

I confirm that the above details are correct:

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

### Index of form numbers

	Ajmaline79
RS1007	Levosimendan
R51008	Hydralazine hydrochloride - Tab 25 mg
	Rasburicase
RS1027	Omeprazole - Tab dispersible 10 mg and 20 mg
<b>RS1028</b>	Diazoxide
RS1035	Levocarnitine19
RS1041	Amikacin
RS1043	Streptomycin sulphate
	Ertapenem
RS1046	Imipenem with cilastatin
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RS1063	Daptomycin
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RS1067	Sulphadiazine
	Teicoplanin
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	Caspofungin
	Clofazimine
RS1078	Dapsone
RS1079	Cycloserine
RS1080	Ethambutol hydrochloride
	Para-aminosalicylic Acid
RS1085	Pyrazinamide
	Rifabutin
	Rifampicin
RS1088	Albendazole
	Artemether with lumefantrine
RS1091	Artesunate
RS1093	Chloroquine phosphate
	Mefloquine hydrochloride
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	Pentamidine isethionate
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	Pyrimethamine
	Sodium stibogluconate
	Spiramycin
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	Paper wasp venom
	Yellow jacket wasp venom
RS1125	Betamethasone valerate with clioquinol
	Methyl aminolevulinate hydrochloride
	Terbutaline
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	Hepatic Products
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R\$1228	Low electrolyte oral feed
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	Icatibant				Coenzyme Q10	
	Extensively hydrolysed formula				Riboflavin	
	Long-acting muscarinic antagonists with long-acting beta-adr				Taurinesodium picosulfate	
	s Haemophilus influenzae type B vaccine				Febuxostat	
	Siltuximab				Cabergoline	
	Ledipasvir with sofosbuvir				Tacrolimus Ointment	
	Idarucizumab				Vigabatrin	
	Plerixafor		RS1	867	Amino acid formula	
	dursulfase				Rosuvastatin	
	Aminolevulinic acid hydrochloride		-		Ranibizumab	
RS1566	Ivabradine	80			Aflibercept	
	Roxithromycin tab dispersible 50 mg				Nicotine	
	Melatonin Pneumococcal (PPV23) polysaccharide vaccine				Abiraterone acetate	
	Rotavirus oral vaccine				COVID-19 treatments Taliglucerase alfa	
	Varicella vaccine [Chickenpox vaccine]				Non-Nucleoside Reverse Transcriptase Inhibitors	
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	Mercaptopurine Hepatitis A vaccine				Gemtuzumab ozogamicin Olaparib	
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	Lysine acetylsalicylate Bevacizumab				Risdiplam Bedaguiline	
	Dexrazoxane				bosentan	
	Calcium carbonate				sildenafil (Vedafil)	
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Long-acting muscarinic antagonists with long-acting beta-adrenocep (RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Methabolic Products (RS2047)	tor agonists 471 506 507 67 107 529 196 254 517 518 523 381 270 140 492 236	Pomalidomide (RS2045) Posaconazole (RS2052) Potassium citrate (RS1133) Povidone-iodine - Vaginal tab 200 mg (RS1354) Preoperative carbohydrate feed 0.5 kcal/ml (RS1415) Preterm formula (RS1224) Primaquine phosphate (RS1097) Propylthiouracil (RS1276) Protease Inhibitors (RS1900) Protein (RS1469) Protionamide (RS1084) Pyrazinamide (RS1084) Pyrazinamide (RS1085) Pyridoxal-5-phosphate (RS1331) Pyrimethamine (RS1098) Quinine dihydrochloride (RS1099)	278 174 116 485 508 500 198 130 206 490 189 182 222 199 200
Long-acting muscarinic antagonists with long-acting beta-adrenocep (RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Methabolic Products (RS2047)	tor agonists 471 506 507 67 107 529 196 254 517 518 523 381 270 140 492 236	Pomalidomide (RS2045) Posaconazole (RS2052) Potassium citrate (RS1133) Povidone-iodine - Vaginal tab 200 mg (RS1354) Preoperative carbohydrate feed 0.5 kcal/ml (RS1415) Preterm formula (RS1224) Primaquine phosphate (RS1097) Propylthiouracil (RS1276) Protease Inhibitors (RS1900) Protein (RS1469) Protionamide (RS1084) Pyrazinamide (RS1084) Pyrazinamide (RS1085) Pyridoxal-5-phosphate (RS1331) Pyrimethamine (RS1098) Quinine dihydrochloride (RS1099) Raloxifene (RS1666)	278 174 116 485 508 500 198 130 206 490 189 189 182 22 22 200 220
Long-acting muscarinic antagonists with long-acting beta-adrenocep (RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Metabolic Products (RS2047) Methoxyflurane (RS1292) Methyl aminolevulinate hydrochloride (RS1127)	tor agonists 471 506 507 67 107 529 196 254 517 518 523 381 270 140 492 236 11	Pomalidomide (RS2045)         Posaconazole (RS2052)         Potassium citrate (RS1133)         Povidone-iodine - Vaginal tab 200 mg (RS1354)         Preoperative carbohydrate feed 0.5 kcal/ml (RS1415)         Preterm formula (RS1224)         Primaquine phosphate (RS1097)         Propylthiouracil (RS1276)         Protease Inhibitors (RS1900)         Protein (RS1469)         Protionamide (RS1084)         Pyrazinamide (RS1084)         Pyrimethamine (RS1085)         Pyrimethamine (RS1098)         Quinine dihydrochloride (RS1099)         Raloxifene (RS1666)         Ranibizumab (RS1870)	278 174 116 485 508 500 198 130 206 490 189 182 222 199 200 226 
Long-acting muscarinic antagonists with long-acting beta-adrenocep (RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Methabolic Products (RS2047)	tor agonists 471 506 507 67 107 529 196 254 517 518 523 381 270 140 492 236 111 16	Pomalidomide (RS2045) Posaconazole (RS2052) Potassium citrate (RS1133) Povidone-iodine - Vaginal tab 200 mg (RS1354) Preoperative carbohydrate feed 0.5 kcal/ml (RS1415) Preterm formula (RS1224) Primaquine phosphate (RS1097) Propylthiouracil (RS1276) Protease Inhibitors (RS1900) Protein (RS1469) Protionamide (RS1084) Pyrazinamide (RS1084) Pyrazinamide (RS1085) Pyridoxal-5-phosphate (RS1331) Pyrimethamine (RS1098) Quinine dihydrochloride (RS1099) Raloxifene (RS1666)	278 174 116 485 508 500 198 130 206 490 189 182 222 220 226 226 327 7
Long-acting muscarinic antagonists with long-acting beta-adrenocep (RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Metabolic Products (RS2047) Methoxyflurane (RS1292) Methyl aminolevulinate hydrochloride (RS1127) Methylnaltrexone bromide (RS2057)	tor agonists 471 506 507 67 107 529 196 254 517 518 523 381 270 140 492 236 111 16 259	Pomalidomide (RS2045)         Posaconazole (RS2052)         Potassium citrate (RS1133)         Povidone-iodine - Vaginal tab 200 mg (RS1354)         Preoperative carbohydrate feed 0.5 kcal/ml (RS1415)         Preterm formula (RS1224)         Primaquine phosphate (RS1097)         Propylthiouracil (RS1276)         Protease Inhibitors (RS1900)         Protein (RS1469)         Protionamide (RS1084)         Pyrazinamide (RS1085)         Pyridoxal-5-phosphate (RS1331)         Pyrimethamine (RS1098)         Quinine dihydrochloride (RS1099)         Raloxifene (RS1666)         Ranibizumab (RS1870)         Ranibizumab (RS1703)	278 174 116 485 508 500 198 130 206 490 189 222 199 200 226 327 7 228
Long-acting muscarinic antagonists with long-acting beta-adrenocep (RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Metabolic Products (RS2047) Methoxyflurane (RS1292) Methyl aminolevulinate hydrochloride (RS1127) Methylphenidate hydrochloride (RS2105)	tor agonists 471 506 507 67 107 529 196 254 517 518 523 381 270 140 492 236 111 16 259 	Pomalidomide (RS2045)         Posaconazole (RS2052)         Potassium citrate (RS1133)         Povidone-iodine - Vaginal tab 200 mg (RS1354)         Preoperative carbohydrate feed 0.5 kcal/ml (RS1415)         Preterm formula (RS1224)         Primaquine phosphate (RS1097)         Propylthiouracil (RS1276)         Protease Inhibitors (RS1900)         Protein (RS1469)         Protionamide (RS1084)         Pyrazinamide (RS1085)         Pyridoxal-5-phosphate (RS1331)         Pyrimethamine (RS1098)         Quinine dihydrochloride (RS1099)         Raloxifene (RS1666)         Ranibizumab (RS1703)         Rasburicase (RS1016)	278 174 116 485 508 500 198 130 206 490 189 22 199 200 226 227 7 228 7
Long-acting muscarinic antagonists with long-acting beta-adrenocep (RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Methoxyflurane (RS1292) Methyl aminolevulinate hydrochloride (RS1127) Methyl aminolevulinate hydrochloride (RS2105) Midodrine (RS1427)	tor agonists 471 506 507 67 107 529 196 254 517 518 523 381 270 140 492 236 111 16 259 81 287	Pomalidomide (RS2045)         Posaconazole (RS2052)         Potassium citrate (RS1133)         Povidone-iodine - Vaginal tab 200 mg (RS1354)         Preoperative carbohydrate feed 0.5 kcal/ml (RS1415)         Preterm formula (RS1224)         Primaquine phosphate (RS1097)         Propylthiouracil (RS1276)         Protease Inhibitors (RS1900)         Protein (RS1469)         Protionamide (RS1084)         Pyrazinamide (RS1085)         Pyridoxal-5-phosphate (RS1331)         Pyrimethamine (RS1098)         Quinine dihydrochloride (RS1099)         Raloxifene (RS1666)         Ranibizumab (RS1870)         Rasburicase (RS1016)         Remdesivir (RS1912)	278 174 116 485 500 198 130 206 490 189 182 222 199 200 226 327 7 7 228 217 288
Long-acting muscarinic antagonists with long-acting beta-adrenocep (RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Metabolic Products (RS2047) Methoxyflurane (RS1292) Methyl aminolevulinate hydrochloride (RS1127) Methylnaltrexone bromide (RS2057) Methylphenidate hydrochloride (RS2105) Midodrine (RS1427) Midostaurin (RS2033)	tor agonists 471 506 507 67 107 529 196 254 517 518 523 381 270 140 492 236 111 16 259 81 257	Pomalidomide (RS2045)         Posaconazole (RS2052)         Potassium citrate (RS1133)         Povidone-iodine - Vaginal tab 200 mg (RS1354)         Preoperative carbohydrate feed 0.5 kcal/ml (RS1415)         Preterm formula (RS1224)         Primaquine phosphate (RS1097)         Propylthiouracil (RS1276)         Protease Inhibitors (RS1900)         Protein (RS1469)         Protionamide (RS1084)         Pyrazinamide (RS1085)         Pyridoxal-5-phosphate (RS1331)         Pyrimethamine (RS1098)         Quinine dihydrochloride (RS1099)         Raloxifene (RS1666)         Ranibizumab (RS1703)         Rasburicase (RS1016)         Remdesivir (RS1912)         Ribociclib (RS2131)	278 174 116 485 500 198 130 206 490 189 182 222 199 200 226 327 7 228 217 228 217 228 31
Long-acting muscarinic antagonists with long-acting beta-adrenocep (RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Methoxyflurane (RS1292) Methyl aminolevulinate hydrochloride (RS1127) Methylphenidate hydrochloride (RS2105) Midodrine (RS1427) Midostaurin (RS2033) Modafinil (RS2106) Moroctocog alfa [Recombinant factor VIII] (RS1706)	tor agonists 471 506 507 67 107 529 254 517 518 523 381 270 140 492 236 111 111 16 259 81 287 257 55	Pomalidomide (RS2045)         Posaconazole (RS2052)         Potassium citrate (RS1133)         Povidone-iodine - Vaginal tab 200 mg (RS1354)         Preoperative carbohydrate feed 0.5 kcal/ml (RS1415)         Preterm formula (RS1224)         Primaquine phosphate (RS1097)         Propylthiouracil (RS1276)         Protease Inhibitors (RS1900)         Protein (RS1469)         Protionamide (RS1084)         Pyrazinamide (RS1085)         Pyridoxal-5-phosphate (RS1331)         Pyrimethamine (RS1098)         Quinine dihydrochloride (RS1099)         Ranibizumab (RS1870)         Rasburicase (RS1016)         Remdesivir (RS1912)         Ribociclib (RS2131)	278 174 116 485 508 500 198 130 206 490 189 182 222 199 200 226 327 7 228 217 228 217 288 217 288 217
Long-acting muscarinic antagonists with long-acting beta-adrenocep (RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Methoxyflurane (RS1292) Methyl aminolevulinate hydrochloride (RS1127) Methylphenidate hydrochloride (RS2105) Midodrine (RS1427) Midostaurin (RS2033) Modafinil (RS2106) Moroctocog alfa [Recombinant factor VIII] (RS1706) Moxifloxacin (RS2129)	tor agonists 471 506 507 67 107 529 254 517 518 523 381 270 140 492 236 111 111 16 259 81 287 257 55 152	Pomalidomide (RS2045)         Posaconazole (RS2052)         Potassium citrate (RS1133)         Povidone-iodine - Vaginal tab 200 mg (RS1354)         Preoperative carbohydrate feed 0.5 kcal/ml (RS1415)         Preterm formula (RS1224)         Primaquine phosphate (RS1097)         Propylthiouracil (RS1276)         Protease Inhibitors (RS1900)         Protein (RS1469)         Protionamide (RS1084)         Pyrazinamide (RS1085)         Pyridoxal-5-phosphate (RS1331)         Pyrimethamine (RS1098)         Quinine dihydrochloride (RS1099)         Raloxifene (RS1666)         Ranibizumab (RS1870)         Rasburicase (RS1016)         Remdesivir (RS1912)         Ribociclib (RS2131)         Riboflavin (RS1833)         Rifaputin (RS1086)         Rifaputin (RS1086)	278 174 116 485 508 500 198 130 206 490 189 182 222 199 200 226 327 7 228 227 228 31 31 186 31 186 183
Long-acting muscarinic antagonists with long-acting beta-adrenocep (RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Methoxyflurane (RS1292) Methyl aminolevulinate hydrochloride (RS1127) Methylphenidate hydrochloride (RS2105) Midodrine (RS1427) Midostaurin (RS2033) Modafinil (RS2106) Moroctocog alfa [Recombinant factor VIII] (RS1706)	tor agonists 471 506 507 67 107 529 254 517 518 523 381 270 140 492 236 11 11 16 259 81 287 255 55 55 	Pomalidomide (RS2045)         Posaconazole (RS2052)         Potassium citrate (RS1133)         Povidone-iodine - Vaginal tab 200 mg (RS1354)         Preoperative carbohydrate feed 0.5 kcal/ml (RS1415)         Preterm formula (RS1224)         Primaquine phosphate (RS1097)         Propylthiouracil (RS1276)         Protease Inhibitors (RS1900)         Protein (RS1469)         Protionamide (RS1084)         Pyrazinamide (RS1085)         Pyridoxal-5-phosphate (RS1331)         Pyrimethamine (RS1098)         Quinine dihydrochloride (RS1099)         Ranibizumab (RS1870)         Ranibizumab (RS1870)         Rasburicase (RS1016)         Remdesivir (RS1912)         Ribociclib (RS2131)         Ribolavin (RS1833)         Rifabutin (RS1086)	278 174 116 485 508 500 198 130 206 490 189 182 222 199 200 226 327 7 228 217 7 288 31 186 31 186 183 
Long-acting muscarinic antagonists with long-acting beta-adrenocep (RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Methoxyflurane (RS1292) Methyl aminolevulinate hydrochloride (RS1127) Methylaltrexone bromide (RS2057) Methylphenidate hydrochloride (RS2105) Midodrine (RS1427) Midostaurin (RS2033) Modafinil (RS2106) Moroctocog alfa [Recombinant factor VIII] (RS1706) Moxifloxacin (RS2129) Multiple Sclerosis (RS1993) Multiple Sclerosis (RS1997)	tor agonists 471 506 507 67 67 529 107 519 254 517 518 523 381 270 140 492 236 111 16 259 81 287 257 55 55 55 52 250 252	Pomalidomide (RS2045)         Posaconazole (RS2052)         Potassium citrate (RS1133)         Povidone-iodine - Vaginal tab 200 mg (RS1354)         Preoperative carbohydrate feed 0.5 kcal/ml (RS1415)         Preterm formula (RS1224)         Primaquine phosphate (RS1097)         Propylthiouracil (RS1276)         Protease Inhibitors (RS1900)         Protionamide (RS1084)         Pyrazinamide (RS1085)         Pyridoxal-5-phosphate (RS1331)         Pyrimethamine (RS1098)         Quinine dihydrochloride (RS1099)         Raloxifene (RS1666)         Ranibizumab (RS1870)         Rasburicase (RS1016)         Remdesivir (RS1912)         Ribociclib (RS2131)         Rifabutin (RS1086)         Rifampicin (RS1087)         Rifampicin (RS1087)         Rifampicin (RS1087)         Rifaximin (RS1416)         Riluzole (RS1351)	278 174 116 485 508 500 198 130 206 490 189 200 226 327 7 228 217 228 311 186 311 186 183 310 206
Long-acting muscarinic antagonists with long-acting beta-adrenocep (RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Methoxyflurane (RS1292) Methyl aminolevulinate hydrochloride (RS1127) Methylaltrexone bromide (RS2057) Methylphenidate hydrochloride (RS2105) Midodrine (RS1427) Midostaurin (RS2033) Modafinil (RS2106) Moroctocog alfa [Recombinant factor VIII] (RS1706) Moxifloxacin (RS2129) Multiple Sclerosis (RS1993)	tor agonists 471 506 507 67 67 	Pomalidomide (RS2045)         Posaconazole (RS2052)         Potassium citrate (RS1133)         Povidone-iodine - Vaginal tab 200 mg (RS1354)         Preoperative carbohydrate feed 0.5 kcal/ml (RS1415)         Preterm formula (RS1224)         Primaquine phosphate (RS1097)         Propylthiouracil (RS1276)         Protease Inhibitors (RS1900)         Protein (RS1469)         Protionamide (RS1084)         Pyrazinamide (RS1085)         Pyridoxal-5-phosphate (RS1331)         Pyrimethamine (RS1098)         Quinine dihydrochloride (RS1099)         Raloxifene (RS1666)         Ranibizumab (RS1870)         Rasiburicase (RS1016)         Remdesivir (RS1912)         Ribociclib (RS2131)         Riboflavin (RS1833)         Rifabutin (RS1086)         Rifappicin (RS1087)         Rifaximin (RS1416)         Rifaximin (RS1416)         Riluzole (RS1351)	278 174 116 485 508 500 198 198 206 206 189 200 226 327 7 228 217 228 217 288 31 186 183 200 226 327 7 228 217 228 217 228 217 228 217 228 217 228 217 228 217 228 217 228 217 228 217 228 217 228 217 228 217 228 217 228 227 227
Long-acting muscarinic antagonists with long-acting beta-adrenocep (RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Methoxyflurane (RS1292) Methyl aminolevulinate hydrochloride (RS1127) Methylaltrexone bromide (RS2057) Methylphenidate hydrochloride (RS2105) Midodrine (RS1427) Midostaurin (RS2033) Modafinil (RS2106) Morofcocg alfa [Recombinant factor VIII] (RS1706) Moxifloxacin (RS2129) Multiple Sclerosis (RS1993) Multiple Sclerosis (RS1997) Multivitamin and mineral supplement (RS1498)	tor agonists 471 506 507 67 107 529 254 517 518 523 381 270 140 492 236 111 16 259 81 111 16 259 81 257 55 152 257 55 152 250 252 40 41	Pomalidomide (RS2045)         Posaconazole (RS2052)         Potassium citrate (RS1133)         Povidone-iodine - Vaginal tab 200 mg (RS1354)         Preoperative carbohydrate feed 0.5 kcal/ml (RS1415)         Preterm formula (RS1224)         Primaquine phosphate (RS1097)         Propylthiouracil (RS1276)         Protease Inhibitors (RS1900)         Protionamide (RS1084)         Pyrazinamide (RS1085)         Pyridoxal-5-phosphate (RS1331)         Pyrimethamine (RS1098)         Quinine dihydrochloride (RS1099)         Raloxifene (RS1666)         Ranibizumab (RS1870)         Rasburicase (RS1016)         Remdesivir (RS1912)         Ribociclib (RS2131)         Rifabutin (RS1086)         Rifampicin (RS1087)         Rifampicin (RS1087)         Rifampicin (RS1087)         Rifaximin (RS1416)	278 174 116 485 508 500 198 130 206 490 189 182 222 199 200 226 327 7 228 217 228 217 288 31 186 183 10 234 256 247
Long-acting muscarinic antagonists with long-acting beta-adrenocep (RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Methoxyflurane (RS1292) Methyl aminolevulinate hydrochloride (RS1127) Methylphenidate hydrochloride (RS2105) Midodrine (RS1427) Midostaurin (RS2033) Modafinil (RS2106) Moroctocog alfa [Recombinant factor VIII] (RS1706) Moxifloxacin (RS2129) Multiple Sclerosis (RS1993) Multiple Sclerosis (RS1997) Multivitamin and mineral supplement (RS1498) Multivitamin renal (RS1499)	tor agonists 471 506 507 67 107 529 196 254 517 518 523 381 270 140 492 236 111 16 259 81 287 255 55 152 250 252 40 41 38	Pomalidomide (RS2045)         Posaconazole (RS2052)         Potassium citrate (RS1133)         Povidone-iodine - Vaginal tab 200 mg (RS1354)         Preoperative carbohydrate feed 0.5 kcal/ml (RS1415)         Preterm formula (RS1224)         Primaquine phosphate (RS1097)         Propylthiouracil (RS1276)         Protease Inhibitors (RS1900)         Protease Inhibitors (RS1900)         Protein (RS1469)         Protonamide (RS1084)         Pyrazinamide (RS1084)         Pyrazinamide (RS1084)         Pyrazinamide (RS1088)         Quinine dihydrochloride (RS1331)         Pyrimethamine (RS1098)         Quinine dihydrochloride (RS1099)         Raloxifene (RS1666)         Ranibizumab (RS1870)         Rasiburicase (RS1016)         Remdesivir (RS1912)         Ribociclib (RS2131)         Ribolfavin (RS1833)         Rifabutin (RS1086)         Rifapicin (RS1087)         Rifampicin (RS1087)         Rifaximin (RS1416)         Riluzole (RS1351)         Risperidone (RS2060)	278 174 116 485 508 500 198 130 206 490 189 182 222 199 200 226 327 7 228 217 228 217 228 217 228 217 228 217 228 217 228 217 228 227 227 228 217 228 227 247 247 244
Long-acting muscarinic antagonists with long-acting beta-adrenocep (RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Methoxyflurane (RS1292) Methyl aminolevulinate hydrochloride (RS1127) Methylynaltrexone bromide (RS2057) Methylphenidate hydrochloride (RS2105) Midodrine (RS1427) Midostaurin (RS2033) Modafinil (RS2106) Moroctocog alfa [Recombinant factor VIII] (RS1706) Moxifloxacin (RS2199) Multiple Sclerosis (RS1993) Multiple Sclerosis (RS1997) Multivitamin and mineral supplement (RS1498) Multivitamin renal (RS1499) Multivitamins - Cap (RS1620)	tor agonists 471 506 507 67 107 529 196 254 517 518 523 381 270 140 492 236 111 16 259 81 287 257 55 152 250 252 40 41 38 38	Pomalidomide (RS2045)         Posaconazole (RS2052)         Potassium citrate (RS1133)         Povidone-iodine - Vaginal tab 200 mg (RS1354)         Preoperative carbohydrate feed 0.5 kcal/ml (RS1415)         Preterm formula (RS1224)         Primaquine phosphate (RS1097)         Propylthiouracil (RS1276)         Protease Inhibitors (RS1900)         Protein (RS1469)         Protoinamide (RS1084)         Pyrazinamide (RS1085)         Pyridoxal-5-phosphate (RS1331)         Pyrimethamine (RS1098)         Quinine dihydrochloride (RS1099)         Raloxifene (RS1666)         Ranibizumab (RS1703)         Rasburicase (RS1016)         Remdesivir (RS1912)         Ribociclib (RS2131)         Riboflavin (RS1833)         Rifapticin (RS1086)         Rifapticin (RS1087)         Rifapticin (RS1087)         Rifaximin (RS1416)         Riluzole (RS1351)         Risperidone (RS2060)         Rituximab (RS1785)	278 174 116 485 500 198 130 206 490 189 182 222 199 200 226 327 77 228 217 228 217 228 31 186 183 183 214 234 234 234 234 234 234
Long-acting muscarinic antagonists with long-acting beta-adrenocep (RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Methoxyflurane (RS1292) Methyl aminolevulinate hydrochloride (RS1127) Methylylautrexone bromide (RS2057) Methylphenidate hydrochloride (RS2105) Midodrine (RS1427) Midostaurin (RS2033) Modafinil (RS2106) Moroctocog alfa [Recombinant factor VIII] (RS1706) Moxifloxacin (RS2199) Multiple Sclerosis (RS1993) Multiple Sclerosis (RS1993) Multiple Sclerosis (RS1997) Multivitamin and mineral supplement (RS1498) Multivitamins - Cap (RS1620) Multivitamins - Powder (RS1178)	tor agonists 471 506 507 67 107 529 196 254 517 518 523 381 270 140 492 236 111 16 259 81 287 257 55 152 250 252 250 252 250 40 41 38 39 262	Pomalidomide (RS2045)         Posaconazole (RS2052)         Potassium citrate (RS1133)         Povidone-iodine - Vaginal tab 200 mg (RS1354)         Preoperative carbohydrate feed 0.5 kcal/ml (RS1415)         Preterm formula (RS1224)         Primaquine phosphate (RS1097)         Propylthiouracil (RS1276)         Protease Inhibitors (RS1900)         Protein (RS1469)         Protoinamide (RS1084)         Pyrazinamide (RS1085)         Pyridoxal-5-phosphate (RS1331)         Pyrimethamine (RS1098)         Quinine dihydrochloride (RS1099)         Raloxifene (RS1666)         Ranibizumab (RS1870)         Rasburicase (RS1016)         Remdesivir (RS1912)         Ribociclib (RS2131)         Rifabutin (RS1086)         Rifabutin (RS1087)         Rifabutin (RS1087)         Rifabutin (RS1416)         Riluzole (RS1351)         Risperidone (RS2060)         Rituximab (RS1785)         Rituximab (RS1785)	278 174 116 485 500 198 130 206 490 189 182 222 199 200 226 327 77 228 217 288 217 27 288 31 186 183 10 234 256 247

Roxithromycin tab dispersible 50 mg (RS1569)		Teriparatide (RS1143)	227
Rurioctocog alfa pegol [Recombinant factor VIII] (RS1682)		Thalidomide (RS2046)	280
Ruxolitinib (RS1726)		Ticagrelor (RS1774)	69
Sacubitril with valsartan (RS2014)	77	Ticarcillin with clavulanic acid (RS1054)	149
Salmonella typhi vaccine (RS1243)		Tigecycline (RS1059)	
Sapropterin dihydrochloride (RS1796)		Tobramcyin (RS1475)	
Secukinumab (RS2119)		Tobramycin (RS1044)	134
Selenium (RS1929)		Tobramycin Solution for inhalation 60 mg per ml, 5 ml (RS1435)	135
Siltuximab (RS1525)		Tocilizumab (RS2125)	
Sirolimus (RS1991)		Tolvaptan (RS1930)	84
Sodium chloride – İnj (RS1297)	74	Trametinib (RS2132)	297
Sodium hyaluronate (RS1175)		Trastuzumab (Herzuma) (RS2005)	410
Sodium phenylbutyrate (RS1797)	20	Trastuzumab deruxtecan (RS2082)	413
Sodium stibogluconate (RS1100)	201	Trastuzumab emtansine (RS2083)	362
Somatropin (RS1826)	123	Trientine (RS2026)	
Spiramycin (RS1101)	202	Upadacitinib (RS2120)	462
Standard Feeds (RS1214)	510	Ursodeoxycholic acid (RS2103)	
Stiripentol (RS1989)	241	Ustekinumab (RS1942)	403
Strand Transfer Inhibitors (RS1901)	207	Valganciclovir (RS1799)	212
Streptomycin sulphate (RS1043)	132	Vancomycin (RS1069)	162
Sucrose (RS1763)		Varenicline (RS1702)	264
Sugammadex (RS1370)		Varicella vaccine [Chickenpox vaccine] (RS1591)	531
Sulphadiazine (RS1067)	158	Varicella zoster vaccine [shingles vaccine] (RS2039)	
Sunitinib (RS2109)		Vedolizumab (RS1943)	405
Tacrolimus (RS2110)		Venetoclax (RS2118)	271
Tacrolimus Ointment (RS1859)	110	Vigabatrin (RS1865)	239
Taliglucerase alfa (RS1897)	27	Voriconazole (RS2053)	172
Tamsulosin (RS1132)	115	Yellow jacket wasp venom (RS1119)	470
Taurine (RS1834)		Zanamivir - Powder for inhalation 5 mg (RS1369)	215
Teicoplanin (RS1068)	159	bosentan (RS1982)	
Temozolomide (RS1994)	279	sildenafil (Vedafil) (RS1983)	97
Terbutaline (RS1130)	113	sodium picosulfate (RS1843)	17