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	CRI	BER		PATIENT:	
Name	:			Name:	
Ward:				NHI:	
Defe	ras	irox			
	sses equi	smen sites Preso		e with a protocol or guideline that has been endorsed by the Health NZ	
and	and	\circ	The patient has been diagnosed with chronic iron overload due Deferasirox is to be given at a daily dose not exceeding 40 mg Or Treatment with maximum tolerated doses of deferiprone have proven ineffective as measured by serum ferritin let Or Treatment with deferiprone has resulted in severe persis Treatment with deferiprone has resulted in arthritis Treatment with deferiprone is contraindicated due to a high	/kg/day monotherapy or deferiprone and desferrioxamine combination therapy vels, liver or cardiac MRI T2*	
Re-a	sses equi	TINUATION seessment required after 2 years equisites (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.			
	or	O O	parameters namely serum ferritin, cardiac MRI T2* and liver M	d has resulted in clinical stability or continued improvement in all three	

I confirm that the above details are correct:	
Signed:	Date: