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:
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.				
	O Supply for anticipated emergency treatment of laryngeal/oro-pharyngeal or severe abdominal attacks of acute hereditary angioede (HAE) for patients with confirmed diagnosis of C1-esterase inhibitor deficiency and			
	O	Ο	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

I confirm that the above details are correct: