## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

July 2024

Use this checklist to determine if a patient meets the restrictions for funding in the **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:			
Fulv	estrant					
INIT	IATION					
Re-assessment required after 6 months						
Prerequisites (tick boxes where appropriate)						
and	O Preso		dance with a protocol or guideline that has been endorsed by the Health NZ			
	O Patient has oestrogen-receptor positive locally advanced or metastatic breast cancer and					
	and	Patient has disease progression following prior treatment with metastatic disease	an aromatase inhibitor or tamoxifen for their locally advanced or			
	and	Treatment to be given at a dose of 500 mg monthly following loading doses				
	O	Treatment to be discontinued at disease progression				
	ITINUATIC					
		t required after 6 months				
Prer	equisites	(tick boxes where appropriate)				
and	O Preso Hosp		dance with a protocol or guideline that has been endorsed by the Health NZ			
	and	Treatment remains appropriate and patient is benefitting from	treatment			
	and	Treatment to be given at a dose of 500 mg monthly				
	O	No evidence of disease progression				

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Signeg	 Date	