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

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Everolimus

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

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

and

- ○ Patient has tuberous sclerosis

and

- ○ Patient has progressively enlarging sub-ependymal giant cell astrocytomas (SEGAs) that require treatment

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

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

and

- ○ Documented evidence of SEGA reduction or stabilisation by MRI within the last 3 months

and

- ○ The treatment remains appropriate and the patient is benefiting from treatment

and

- ○ Everolimus to be discontinued at progression of SEGAs

I confirm that the above details are correct:

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