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: .....

Upadacitinib

INITIATION – Rheumatoid Arthritis (patients previously treated with adalimumab or etanercept)
Re-assessment required after 6 months
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

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

and

- ○ The patient has experienced intolerable side effects from adalimumab and/or etanercept

or

- ○ 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

- ○ The patient is seronegative for both anti-cyclic citrullinated peptide (CCP) antibodies and rheumatoid factor

or

- ○ The patient has been started on rituximab for rheumatoid arthritis in a Health NZ Hospital

and

- ○ The patient has experienced intolerable side effects from rituximab

or

- ○ 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

CONTINUATION – Rheumatoid Arthritis
Re-assessment required after 6 months
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

- ○ Following 6 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

- ○ 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: .....