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: .....

Octreotide

INITIATION – Malignant bowel obstruction

Prerequisites (tick boxes where appropriate)

- ☐ The patient has nausea* and vomiting* due to malignant bowel obstruction*

and

- ☐ Treatment with antiemetics, rehydration, antimuscarinic agents, corticosteroids and analgesics for at least 48 hours has failed

and

- ☐ Octreotide to be given at a maximum dose 1500 mcg daily for up to 4 weeks

Note: Indications marked with * are unapproved indications

INITIATION – acromegaly

Re-assessment required after 3 months

Prerequisites (tick boxes where appropriate)

- ☐ The patient has acromegaly

and

- ☐ Treatment with surgery, radiotherapy and a dopamine agonist has failed

or

- ☐ Treatment with octreotide is for an interim period while awaiting the effects of radiotherapy and a dopamine agonist has failed

or

- ☐ The patient is unwilling, or unable, to undergo surgery and/or radiotherapy

CONTINUATION – acromegaly

Prerequisites (tick boxes where appropriate)

- ☐ IGF1 levels have decreased since starting octreotide

and

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

Note: In patients with acromegaly octreotide treatment should be discontinued if IGF1 levels have not decreased after 3 months treatment. In patients treated with radiotherapy octreotide treatment should be withdrawn every 2 years, for 1 month, for assessment of remission. Octreotide treatment should be stopped where there is biochemical evidence of remission (normal IGF1 levels) following octreotide treatment withdrawal for at least 4 weeks.

I confirm that the above details are correct:

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

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: .....

Octreotide *- continued*

INITIATION – Other indications
Prerequisites (tick boxes where appropriate)

- ○ VIPomas and glucagonomas - for patients who are seriously ill in order to improve their clinical state prior to definitive surgery

or

- ○ Gastrinoma

and

- ○ Patient has failed surgery

or

- ○ Patient in metastatic disease after H2 antagonists (or proton pump inhibitors) have failed

or

- ○ Insulinomas

and

- ○ Surgery is contraindicated or has failed

or

- ○ For pre-operative control of hypoglycaemia and for maintenance therapy

or

- ○ Carcinoid syndrome (diagnosed by tissue pathology and/or urinary 5HIAA analysis)

and

- ○ Disabling symptoms not controlled by maximal medical therapy

Note: restriction applies only to the long-acting formulations of octreotide

INITIATION – pre-operative acromegaly
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

- ○ Patient has acromegaly

and

- ○ Patient has a large pituitary tumour, greater than 10 mm at its widest

and

- ○ Patient is scheduled to undergo pituitary surgery in the next six months

Note: Indications marked with * are unapproved indications

CONTINUATION – Acromegaly - pandemic circumstances
Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)

- ○ Patient has acromegaly

and

- ○ The patient is clinically benefiting from treatment and continued treatment remains appropriate

and

- ○ The regular renewal requirements cannot be met due to COVID-19 constraints on the health sector

I confirm that the above details are correct:

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