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: .....

Tolvaptan

INITIATION – autosomal dominant polycystic kidney disease
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a renal physician or any relevant practitioner on the recommendation of a renal physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ○ Patient has a confirmed diagnosis of autosomal dominant polycystic kidney disease

and

- ○ Patient has an estimated glomerular filtration rate (eGFR) of greater than or equal to 25 ml/min/1.73 m^2 at treatment initiation

and

- ○ Patient's disease is rapidly progressing, with a decline in eGFR of greater than or equal to 5 mL/min/1.73 m^2 within one-year

or

- ○ Patient's disease is rapidly progressing, with an average decline in eGFR of greater than or equal to 2.5 mL/min/1.73 m^2 per year over a five-year period

CONTINUATION – autosomal dominant polycystic kidney disease
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a renal physician or any relevant practitioner on the recommendation of a renal physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ○ Patient has not developed end-stage renal disease, defined as an eGFR of less than 15 mL/min/1.73 m^2

and

- ○ Patient has not undergone a kidney transplant

HOSPITAL

I confirm that the above details are correct:

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