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:	
Ward:	NHI:
Epoprostend	
Prerequisites (dual therapy uired after 6 months boxes where appropriate) d by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of bry specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and	
and	ent has pulmonary arterial hypertension (PAH)
and	H is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications H is in New York Heart Association/World Health Organization (NYHA/WHO) functional class III or IV
or	PAH has been confirmed by right heart catheterisation A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair) A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵) PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) † O Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool** O Patient has PAH other than idiopathic / heritable or drug-associated type Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures
and	Epoprostenol is to be used as part of PAH dual therapy with either sildenafil or an endothelin receptor antagonist Patient is presenting in NYHA/WHO functional class IV Patient has tried a PAH monotherapy for at least three months and remains in an unacceptable risk category according to a validated risk stratification tool

Signed: Date:

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.

CRIBER	PATIENT:
:	Name:
	NHI:
prostenol - co	ontinued
Prescribed k a respiratory Hospital. Patier and PAH is	iple therapy red after 6 months oxes where appropriate) by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation by specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health N on the pulmonary arterial hypertension (PAH) is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications is in New York Heart Association/World Health Organization (NYHAWHO) functional class III or IV On PAH has been confirmed by right heart catheterisation
and and and	A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair) A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵)
or O	Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures Epoprostenol is to be used as PAH triple therapy Patient is on the lung transplant list Patient is presenting in NYHA/WHO functional class IV Patient has tried PAH dual therapy for at least three months and has not experienced an acceptable response to treatment according to a validated risk stratification tool
	and Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario

I confirm that the above details are correct:

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:	Name:			
Ward:	NHI:			
Epoprostenol - continued				
CONTINUATION Re-assessment required after 2 years Prerequisites (tick box where appropriate)				
Prescribed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and Patient is continuing to derive benefit from epoprostenol treatment according to a validated PAH risk stratification tool				

Note: † The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the diagnosis and treatment of pulmonary hypertension PAH

** the requirement to use a validated risk stratification tool to determine insufficient response applies to adults. Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

I confirm that the above details are correct: Signed: Date: