Therapeutic Groups

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Alimentary Tract and Metabolism

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:	
Calcium carbonate		

Prerequisites (tick box where appropriate)

O Only when prescribed for patients unable to swallow calcium carbonate tablets or where calcium carbonate tablets are inappropriate.

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:	

Budesonide

(and	О	Mild to moderate ileal, ileocaecal or proximal Crohn's disease
		O Diabetes
	or	O Cushingoid habitus
	or	O Osteoporosis where there is significant risk of fracture
	or	O Severe acne following treatment with conventional corticosteroid therapy
or O History of severe psychiatric problems associated with corticosteroid treatment or O History of major mental illness (such as bipolar affective disorder) where the risk of conventional corticosteroid treatment causing relapse is considered to be high		O History of severe psychiatric problems associated with corticosteroid treatment
	or	O Relapse during pregnancy (where conventional corticosteroids are considered to be contraindicated)
NITIATION – Collagenous and lymphocytic colitis (microscopic colitis) prerequisites (tick box where appropriate)		
O Patient has a diagnosis of microscopic colitis (collagenous or lymphocytic colitis) by colonoscopy with biopsies		
NITIATION – Gut Graft versus Host disease		

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.

PRESC	RIB	ER			PATIENT:
Name:					Name:
Ward:					NHI:
Budes	son	ide	- con	tinued	
Re-ass	essi	ment	t requi	rrhotic autoimmune hepatitis ired after 6 months oxes where appropriate)	
	(С	Patier	nt has autoimmune hepatitis*	
	nd (nd	С	Patier	nt does not have cirrhosis	
			Ο	Diabetes	
or O Cushingoid habitus					
	or O Osteoporosis where there is significant risk of fracture or O Severe acne following treatment with conventional corticosteroid therapy or O History of severe psychiatric problems associated with corticosteroid treatment				
			osteroid therapy		
			orticosteroid treatment		
		or or		History of major mental illness (such as bipolar affective causing relapse is considered to be high	disorder) where the risk of conventional corticosteroid treatment
			Ο	Relapse during pregnancy (where conventional corticost	eroids are considered to be contraindicated)
		or	Ο	Adolescents with poor linear growth (where conventional	corticosteroid use may limit further growth)
Note: Indications marked with * are unapproved indications.					
CONTINUATION – non-cirrhotic autoimmune hepatitis Re-assessment required after 6 months Prerequisites (tick box where appropriate)					
C) т	reatr	nent r	emains appropriate and the patient is benefitting from the	treatment

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:
Rani	tid	ine	
INITIATION Prerequisites (tick boxes where appropriate)			
	~	O For continuation use	
	or	O Routine prevention of allergic reactions.	
\subseteq			

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:
Omeprazole - Tab dispersible 20 mg	
INITIATION Prerequisites (tick box where appropriate)	
O Only for use in tube-fed patients	

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:	
L-ornithine L-aspartate		

INITIATION

Prerequisites (tick box where appropriate)

()For patients with chronic hepatic encephalopathy who have not responded to treatment with, or are intolerant to lactulose, or where lactulose is contraindicated

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:
Rifaximin	
INITIATION	
Prerequisites (tick box where appropriate)	

 $m O\,$ For patients with hepatic encephalopathy despite an adequate trial of maximum tolerated doses of lactulose

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:
Diazoxide	
INITIATION Prerequisites (tick box where appropriate)	
m O For patients with confirmed hypoglycaemia caused by hyperinsulinis	m

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:	

Empagliflozin; Empagliflozin with metformin hydrochloride

or	OF	For co	ontinuation use
or	O f	Patier	nt has previously had an initial approval for a GLP-1 agonist
	and	0	Patient has type 2 diabetes
			O Patient is Māori or any Pacific ethnicity*
		or	O Patient has pre-existing cardiovascular disease or risk equivalent (see note a)*
			O Patient has an absolute 5-year cardiovascular disease risk of 15% or greater according to a validated cardiovascular risk assessment calculator*
		or	O Patient has a high lifetime cardiovascular risk due to being diagnosed with type 2 diabetes during childhood or as a young adult*
		or	O Patient has diabetic kidney disease (see note b)*
	and		Target HbA1c (of 53 mmol/mol or less) has not been achieved despite the regular use of at least one blood-glucose lowering agent (e.g. metformin, vildagliptin, or insulin) for at least 3 months
* Ci	riteria i	ntenc	ded to describe patients at high risk of cardiovascular or renal complications of diabetes.

b) Diabetic kidney disease defined as: persistent albuminuria (albumin:creatinine ratio greater than or equal to 3 mg/mmol, in at least two out of three samples over a 3-6 month period) and/or eGFR less than 60 mL/min/1.73m2 in the presence of diabetes, without alternative cause.

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:	
Ursodeoxycholic acid		
INITIATION – Alagille syndrome or progressive familial intrahepatic cholo Prerequisites (tick boxes where appropriate)	estasis	
O Patient has been diagnosed with Alagille syndrome		
O Patient has progressive familial intrahepatic cholestasis		
INITIATION – Chronic severe drug induced cholestatic liver injury Prerequisites (tick boxes where appropriate)		
Patient has chronic severe drug induced cholestatic liver injury	,	
Cholestatic liver injury not due to Total Parenteral Nutrition (TF	N) use in adults	
Treatment with ursodeoxycholic acid may prevent hospital adn	hission or reduce duration of stay	
Prerequisites (tick boxes where appropriate) Primary biliary cholangitis confirmed by antimitochondrial antitive without raised serum IgM or, if AMA is negative by liver biopsy and O Patient not requiring a liver transplant (bilirubin > 100 umol/l; d		
INITIATION – Pregnancy Prerequisites (tick box where appropriate) O Patient diagnosed with cholestasis of pregnancy		
INITIATION – Haematological transplant Prerequisites (tick boxes where appropriate)		
 Patient at risk of veno-occlusive disease or has hepatic impair cell or bone marrow transplantation Treatment for up to 13 weeks 	ment and is undergoing conditioning treatment prior to allogenic stem	
INITIATION – Total parenteral nutrition induced cholestasis Prerequisites (tick boxes where appropriate)		
O Paediatric patient has developed abnormal liver function as inc	dicated on testing which is likely to be induced by TPN	
C Liver function has not improved with modifying the TPN compo	osition	

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:
Ursodeoxycholic acid - continued	
INITIATION – prevention of sinusoidal obstruction syndrome Re-assessment required after 6 months	
Prerequisites (tick boxes where appropriate)	
The patient is enrolled in the Children's Oncology Group AAL	_1732 trial
The patient has leukaemia/lymphoma and is receiving inotuzu	imab ozogamicin

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.

PRESCRIE	BER		PATIENT:		
Name:			Name:		
Ward:			NHI:		
Methylna	Methylnaltrexone bromide				
		Opioid induced constipation (tick boxes where appropriate)			
and		The patient is receiving palliative care			
		O Oral and rectal treatments for opioid induced constipation are ineffective			
	or	O Oral and rectal treatments for opioid induced constipation	n are unable to be tolerated		

I confirm that the above details are correct:

Signed: Date:

 \bigcirc

and ()

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	PATIENT:
Name:	Name:
Ward:	NHI:
sodium picosulfate	
INITIATION Prerequisites (tick boxes where appropriate)	

The patient is a child with problematic constipation despite an adequate trial of other oral pharmacotherapies including macrogol where practicable

The patient would otherwise require a high-volume bowel cleansing preparation

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:

Betaine

()

Re-a		smer		uired after 12 months boxes where appropriate)
and			cribeo lospit	d by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health tal.
	and	0	The	patient has a confirmed diagnosis of homocystinuria
		or	\bigcirc	A cystathionine beta-synthase (CBS) deficiency A 5,10-methylene-tetrahydrofolate reductase (MTHFR) deficiency
		or	0	A disorder of intracellular cobalamin metabolism
	and	0	An a	appropriate homocysteine level has not been achieved despite a sufficient trial of appropriate vitamin supplementation
	ITINU Issess			uired after 12 months

Prerequisites (tick box where appropriate)

O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

The treatment remains appropriate and the patient is benefiting from treatment

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	PATIENT:
Name:	Name:
Ward:	NHI:
Levocarnitine	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a neurologist, metabolic physician or metabolic disorders dietitian, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:		
Sodium phenylbutyrate			
INITIATION Re-assessment required after 12 months Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by a metabolic physician, or in accondition NZ Hospital.	ordance with a protocol or guideline that has been endorsed by the Health		

For the chronic management of a urea cycle disorder involving a deficiency of carbamylphosphate synthetase, ornithine transcarbamylase or argininosuccinate synthetase

CONTINUATION

()

and

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

The treatment remains appropriate and the patient is benefiting from treatment

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	PATIENT:
Name:	Name:
Ward:	NHI:
Biotin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a metabolic physician or metabolic disorders dietitian, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:			
Pyridoxal-5-phosphate				

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a neurologist, metabolic physician or metabolic disorders dietitian, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:

Galsulfase

and

	TION sessment required after 12 months juisites (tick boxes where appropriate)
Field	unances (lick boxes where appropriate)
and	Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	O The patient has been diagnosed with mucopolysaccharidosis VI
	O Diagnosis confirmed by demonstration of N-acetyl-galactosamine-4-sulfatase (arylsulfatase B) deficiency confirmed by either enzyme activity assay in leukocytes or skin fibroblasts
	O Detection of two disease causing mutations and patient has a sibling who is known to have mucopolysaccharidosis VI
	INUATION
	sessment required after 12 months
Prerec	uisites (tick boxes where appropriate)
and	Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	O The treatment remains appropriate for the patient and the patient is benefiting from treatment
	O Patient has not had severe infusion-related adverse reactions which were not preventable by appropriate pre-medication and/or adjustment of infusion rates
1	And O Patient has not developed another life threatening or severe disease where the long term prognosis is unlikely to be influenced by

Enzyme Replacement Therapy (ERT)

Patient has not developed another medical condition that might reasonably be expected to compromise a response to ERT

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:	

Alglucosidase Alfa

INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and () The patient is aged up to 24 months at the time of initial application and has been diagnosed with infantile Pompe disease and () Diagnosis confirmed by documented deficiency of acid alpha-glucosidase by prenatal diagnosis using chorionic villus biopsies and/or cultured amniotic cells or Documented deficiency of acid alpha-glucosidase, and urinary tetrasaccharide testing indicating a diagnostic elevation of glucose tetrasaccharides or Documented deficiency of acid alpha-glucosidase, and documented molecular genetic testing indicating a disease-causing mutation in the acid alpha-glucosidase gene (GAA gene) or Documented urinary tetrasaccharide testing indicating a diagnostic elevation of glucose tetrasaccharides, and molecular genetic testing indicating a disease-causing mutation in the GAA gene and) Patient has not required long-term invasive ventilation for respiratory failure prior to starting enzyme replacement therapy (ERT) and () Patient does not have another life-threatening or severe disease where the prognosis is unlikely to be influenced by ERT or might be reasonably expected to compromise a response to ERT and Alglucosidase alfa to be administered at doses no greater than 20 mg/kg every 2 weeks

Re-a	CONTINUATION Re-assessment required after 12 months						
Prer	equisite	s (tick boxes where appropriate)					
and	O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.						
	C	The treatment remains appropriate for the patient and the patient is benefiting from treatment					
	and and	Alglucosidase alfa to be administered at doses no greater than 20 mg/kg every 2 weeks					
	C	Patient has not had severe infusion-related adverse reactions which were not preventable by appropriate pre-medication and/or adjustment of infusion rates					
	and	Patient has not developed another life threatening or severe disease where the long term prognosis is unlikely to be influenced by ERT					
	and	Patient has not developed another medical condition that might reasonably be expected to compromise a response to ERT					
	and	There is no evidence of life threatening progression of respiratory disease as evidenced by the needed for > 14 days of invasive ventilation					
	and	There is no evidence of new or progressive cardiomyopathy					

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:

Idursulfase

INITIATION Re-assessment required after 24 weeks				
Prere	equis	ites	(tick boxes where appropriate)	
O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the He NZ Hospital.				
	O The patient has been diagnosed with Hunter Syndrome (mucopolysacchardosis II)			
		or	O Diagnosis confirmed by demonstration of iduronate 2-sulfatase deficiency in white blood cells by either enzyme assay in cultured skin fibroblasts	
			O Detection of a disease causing mutation in the iduronate 2-sulfatase gene	
	and			
	and	С	Patient is going to proceed with a haematopoietic stem cell transplant (HSCT) within the next 3 months and treatment with idursulfase would be bridging treatment to transplant	
	(С	Patient has not required long-term invasive ventilation for respiratory failure prior to starting Enzyme Replacement Therapy (ERT)	
and		С	Idursulfase to be administered for a total of 24 weeks (equivalent to 12 weeks pre- and 12 weeks post-HSCT) at doses no greater than 0.5 mg/kg every week	

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:

Laronidase

			t roqui	ired after 24 weeks
				oxes where appropriate)
O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and				
	(and	С	The p	patient has been diagnosed with Hurler Syndrome (mucopolysacchardosis I-H)
		or	0	Diagnosis confirmed by demonstration of alpha-L-iduronidase deficiency in white blood cells by either enzyme assay in cultured skin fibroblasts
			0	Detection of two disease causing mutations in the alpha-L-iduronidase gene and patient has a sibling who is known to have Hurler syndrome
	and (С		nt is going to proceed with a haematopoietic stem cell transplant (HSCT) within the next 3 months and treatment with laronidase d be bridging treatment to transplant
	and (and	С	Patier	nt has not required long-term invasive ventilation for respiratory failure prior to starting Enzyme Replacement Therapy (ERT)
	(С		hidase to be administered for a total of 24 weeks (equivalent to 12 weeks pre- and 12 post-HSCT) at doses no greater than inits/kg every week

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:

Taliglucerase alfa

ΙΝΙΤ	ΙΑΤΙΟ	N				
Re-assessment required after 12 months						
Prei	Prerequisites (tick boxes where appropriate)					
and		Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
	and	0	The patient has a diagnosis of symptomatic type 1 or type 3* Gaucher disease confirmed by the demonstration of specific deficiency of glucocerebrosidase in leukocytes or cultured skin fibroblasts, and genotypic analysis Patient does not have another life-threatening or severe disease where the prognosis is unlikely to be influenced by enzyme			
	and	I	replacement therapy (ERT) or the disease might be reasonably expected to compromise a response to ERT			
		or	O Patient has haematological complications of Gaucher disease			
			O Patient has skeletal complications of Gaucher disease			
		or	O Patient has significant liver dysfunction or hepatomegaly attributable to Gaucher disease			
		or	O Patient has reduced vital capacity from clinically significant or progressive pulmonary disease due to Gaucher disease			
			O Patient is a child and has experienced growth failure with significant decrease in percentile linear growth over a 6-12 month period			
	and	0	Taliglucerase alfa is to be administered at a dose no greater than 30 unit/kg every other week rounded to the nearest whole vial (200 units)			
Note	e: Ind	icatio	n marked with * is an unapproved indication			
Re-a		smer	The transmission of transmission of the transmission of the transmission of transmissi			
and			bribed by, or recommended by a metabolic physician or any relevant practitioner on the recommendation of a metabolic physician, or in rdance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
		0	Patient has demonstrated a symptomatic improvement and has maintained improvements in the main symptom or symptoms for which therapy was started			
	and	0	Patient has demonstrated a clinically objective improvement or no deterioration in haemoglobin levels, platelet counts and liver and spleen size			
	and	0	RRadiological (MRI) signs of bone activity performed at two years since initiation of treatment, and five yearly thereafter, demonstrate no deterioration shown by the MRI, compared with MRI taken immediately prior to commencement of therapy or adjusted dose			
	and	Ο	Patient has not developed another medical condition that might reasonably be expected to compromise a response to ERT			
	and	0	Patient is adherent with regular treatment and taliglucerase alfa is to be administered at a dose no greater than 30 unit/kg every other week rounded to the nearest whole vial (200 units)			

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:

Sapropterin dihydrochloride

		nent required after 1 month		
Prerequisites (tick boxes where appropriate)				
ricicqu				
and		rescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health Z Hospital.		
	C	O Patient has phenylketonuria (PKU) and is pregnant or actively planning to become pregnant		
and O Treatment with sapropterin is required to support management of PKU during pregnancy and				
ar	(${\sf O}$ Sapropterin to be administered at doses no greater than a total daily dose of 20 mg/kg		
ar	(O Sapropterin to be used alone or in combination with PKU dietary management		
	$\left(\right)$	Total treatment duration with sapropterin will not exceed 22 months for each pregnancy (includes time for planning and becoming pregnant) and treatment will be stopped after delivery		
	essm uisit Pr	ITION nent required after 12 months tes (tick boxes where appropriate) rescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health Z Hospital.		
		 Following the initial one-month approval, the patient has demonstrated an adequate response to a 2 to 4 week trial of sapropterin with a clinically appropriate reduction in phenylalanine levels to support management of PKU during pregnancy On subsequent renewal applications, the patient has previously demonstrated response to treatment with sapropterin and maintained adequate phenylalanine levels to support management of PKU during pregnancy 		
ar		O Patient continues to be pregnant and treatment with sapropterin will not continue after delivery		
		or O Patient is actively planning a pregnancy and this is the first renewal for treatment with sapropterin or		
		O Treatment with sapropterin is required for a second or subsequent pregnancy to support management of their PKU during pregnancy		
ar ar	nd	 Sapropterin to be administered at doses no greater than a total daily dose of 20 mg/kg Sapropterin to be used alone or in combination with PKU dietary management 		
ar		Total treatment duration with sapropterin will not exceed 22 months for each pregnancy (includes time for planning and becoming pregnant) and treatment will be stopped after delivery		

Signed:	 Date:
- 3	

and

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	PATIENT:
Name:	Name:
Ward:	NHI:
Carglumic Acid	
INITIATION Prerequisites (tick box where appropriate)	

()Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

O For the acute in-patient treatment of organic acidaemias as an alternative to haemofiltration

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:
Coenzyme Q10	
INITIATION Re-assessment required after 6 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a metabolic physician, or in acco NZ Hospital. and O The patient has a suspected inborn error of metabolism that may res	ordance with a protocol or guideline that has been endorsed by the Health spond to coenzyme Q10 supplementation
CONTINUATION Re-assessment required after 24 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a metabolic physician, or in acco NZ Hospital. and O The patient has a confirmed diagnosis of an inborn error of me and O The treatment remains appropriate and the patient is benefitin	

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:
Riboflavin	
INITIATION Re-assessment required after 6 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a metabolic physician or neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O The patient has a suspected inborn error of metabolism that may respond to riboflavin supplementation	
CONTINUATION Re-assessment required after 24 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a metabolic physician or neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O The patient has a confirmed diagnosis of an inborn error of metabolism that responds to riboflavin supplementation and O The treatment remains appropriate and the patient is benefiting from treatment	

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	PATIENT:
Name:	Name:
Ward:	NHI:
Taurine	
INITIATION Re-assessment required after 6 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O The patient has a suspected specific mitochondrial disorder that may respond to taurine supplementation	
CONTINUATION Re-assessment required after 24 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Image: Content of the patient has a confirmed diagnosis of a specific mitochondrial disorder which responds to taurine supplementation	
The treatment remains appropriate and the patient is benefiting	g from treatment

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:
Trientine	
and Treatment with zinc has been trialled and discontinued becau	nued because the person has experienced intolerable side effects or has use the person has experienced intolerable side effects or has not ppropriate as the person has symptomatic liver disease and requires

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.

PRES	SCRIBER	PATIENT:
Name	5:	Name:
Ward	:	NHI:
Сор	per chloride	
Re-a	ATION – Moderate to severe burns ssessment required after 3 months	
Prer	equisites (tick boxes where appropriate)	
	O Patient has been hospitalised with moderate to severe burns	
	O Treatment is recommended by a National Burns Unit specialis	t

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:
Ferric carboxymaltose	
INITIATION Prerequisites (tick box where appropriate)	
O Treatment with oral iron has proven ineffective or is clinically inappro	ppriate

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.

PRES	CRIBER	PATIENT:
Name		Name:
Ward		NHI:
Sele	nium	
	ATION – Moderate to severe burns ssessment required after 3 months	
Prer	equisites (tick boxes where appropriate)	
	O Patient has been hospitalised with moderate to severe burns	
	O Treatment is recommended by a National Burns Unit specialis	t

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:
Sodium hyaluronate	

INITIATION

Prerequisites (tick box where appropriate)

()Prescribed by, or recommended by an otolaryngologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

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.

PRES	SCRI	BER		PATIENT:		
Name: 1				Name:		
Ward	:			NHI:		
Mult	Multivitamins - Cap					
INITIATION Prerequisites (tick boxes where appropriate)						
		Ο	Patient has cystic fibrosis with pancreatic insufficiency			
	or	Ο	Patient is an infant or child with liver disease or short gut synd	rome		
	or	0	Patient has severe malabsorption syndrome			

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:		
Multivitamins – Powder			
INITIATION Prerequisites (tick box where appropriate)			
O Patient has inborn errors of metabolism			

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.

PRES	CRIB	ER			PATIENT:
Name	:				Name:
Ward:					NHI:
Multi	vita	min	and	mineral supplement	
	ssess	men ites	(tick b	ired after 3 months poxes where appropriate) nt was admitted to hospital with burns	
	and	or or	0 0 0	Burn size is greater than 15% of total body surface area Burn size is greater than 10% of BSA for mid-dermal or o Nutritional status prior to admission or dietary intake is p	deep dermal burns

or

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	PATIENT:
Name:	Name:
Ward:	NHI:
Multivitamin renal	
Prerequisites (tick boxes where appropriate)	

 \bigcirc The patient has chronic kidney disease and is receiving either peritoneal dialysis or haemodialysis

The patient has chronic kidney disease grade 5, defined as patient with an estimated glomerular filtration rate of < 15 ml/min/1.73m² body surface area (BSA)

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.

PRES	SCRIE	BER			PATIENT:	
Name	ə:				Name:	
Ward:					NHI:	
Alph	Alpha tocopheryl acetate					
			-	fibrosis oxes where appropriate)		
	and	0	Cysti	c fibrosis patient		
		or	0	Patient has tried and failed the other available funded fa	soluble vitamin A,D,E,K supplement (Vitabdeck)	
			0	The other available funded fat soluble vitamin A,D,E,K s the patient	upplement (Vitabdeck) is contraindicated or clinically inappropriate for	
	equis	ites	(tick b	radionecrosis ox where appropriate)		
<u> </u>		-or tr	ne trea	tment of osteoradionecrosis		
				indications oxes where appropriate)		
	and	Ο	Infan	t or child with liver disease or short gut syndrome		
	and		Requ	ires vitamin supplementation		
			Ο	Patient has tried and failed the other available funded fa	soluble vitamin A,D,E,K supplements (Vitabdeck)	
		or	Ο	The other available funded fat soluble vitamin A,D,E,K s patient	upplement (Vitabdeck) is contraindicated or clinically inappropriate for	

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:		

Alpha tocopheryl

INITIATION – Cystic fibrosis Prerequisites (tick boxes where appropriate)					
O Cystic fibrosis patient and					
O Patient has tried and failed the other available funded fat soluble vitar	nin A,D,E,K supplement (Vitabdeck)				
O The other available funded fat soluble vitamin A,D,E,K supplement (V the patient	itabdeck) is contraindicated or clinically inappropriate for				
INITIATION – Osteoradionecrosis					
Prerequisites (tick box where appropriate)					
O For the treatment of osteoradionecrosis	O For the treatment of osteoradionecrosis				
INITIATION – Other indications Prerequisites (tick boxes where appropriate)					
O Infant or child with liver disease or short gut syndrome					
O Requires vitamin supplementation					
O Patient has tried and failed the other available funded fat soluble vitar	nin A,D,E,K supplements (Vitabdeck)				
O The other available funded fat soluble vitamin A,D,E,K supplement (V patient	itabdeck) is contraindicated or clinically inappropriate for				

Blood and Blood Forming Organs

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:		

Epoetin beta

and	D Patient in	n chronic renal failure	
and) Haemog	obin is less than or equal to 100g/L	
	and	 Patient does not have diabetes mellitus Glomerular filtration rate is less than or equal to 30ml/min 	
	or and	 Patient has diabetes mellitus Glomerular filtration rate is less than or equal to 45ml/min 	

INITIATION – myelodysplasia*

Re-assessment required after 12 months	
·	

Prerequisites (tick boxes where appropriate)

and	O	Patient has a confirmed diagnosis of myelodysplasia (MDS)
and	Ο	Has had symptomatic anaemia with haemoglobin < 100g/L and is red cell transfusion-dependent
an	Ö	Patient has very low, low or intermediate risk MDS based on the WHO classification-based prognostic scoring system for myelodysplastic syndrome (WPSS)
and	d	Other causes of anaemia such as B12 and folate deficiency have been excluded
and	Ο	Patient has a serum epoetin level of < 500 IU/L
and	٥	The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week

CONTINUATION – myelodysplasia*

Re-assessment required after 2 months
Prerequisites (tick boxes where appropriate)

 O
 The patient's transfusion requirement continues to be reduced with epoetin treatment

 and
 O

 Transformation to acute myeloid leukaemia has not occurred

 and
 O

 The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week

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:	
Epoetin beta - continued		
INITIATION – all other indications Prerequisites (tick boxes where appropriate)		
Haematologist		
O For use in patients where blood transfusion is not a viable trea	tment alternative	
And *Note: Indications marked with * are unapproved indications		

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:								

Epoetin alfa

(and	D Patient in	n chronic renal failure	
and	C Haemogl	obin is less than or equal to 100g/L	
	and	 Patient does not have diabetes mellitus Glomerular filtration rate is less than or equal to 30ml/min 	
	or and	 Patient has diabetes mellitus Glomerular filtration rate is less than or equal to 45ml/min 	

INITIATION – myelodysplasia*

Re-assessment required after 2 months

Prerequisites (tick boxes where appropriate)

	O nd	Patient has a confirmed diagnosis of myelodysplasia (MDS)
		Has had symptomatic anaemia with haemoglobin < 100g/L and is red cell transfusion-dependent
a	0	Patient has very low, low or intermediate risk MDS based on the WHO classification-based prognostic scoring system for myelodysplastic syndrome (WPSS)
		Other causes of anaemia such as B12 and folate deficiency have been excluded
	nd O nd	Patient has a serum epoetin level of < 500 IU/L
	0	The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week

CONTINUATION – myelodysplasia*

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

 O
 The patient's transfusion requirement continues to be reduced with epoetin treatment

 and
 O

 Transformation to acute myeloid leukaemia has not occurred

 and
 O

 The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week

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:							
Epoetin alfa - continued								
INITIATION – all other indications								
Prerequisites (tick box where appropriate)								
O Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.								
And O For use in patients where blood transfusion is not a viable treatment alternative								
Note: Indications marked with * are unapproved indications								

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.

PRES	SCR	BER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Apro	otin	in		
INITI Prer (Preso	(tick boxes where appropriate) cribed by, or recommended by a cardiac anaesthetist, or in according on the second second second second second	ordance with a protocol or guideline that has been endorsed by the Health
and		0	Paediatric patient undergoing cardiopulmonary bypass procec	lure
	or	0	Adult patient undergoing cardiac surgical procedure where the effects of the drug	e significant risk of massive bleeding outweighs the potential adverse

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.

PRES	CR	IBER													F	PATIE	ENT:													
Name	:														N	lame	:													
Ward:															N	IHI:														
Eltro	mb	ора	g																											
Re-a	sses	Pres Hosp	nt requ (tick I cribec bital. Patie	uire Dox by ent im	ic thro d after es who , or red has ha munos	6 we ere a comm d a s	eeks oprop nende splene essive	ed by ecton e the	ny rapie	aema s hav	tolog ve be	ist, or en tria	r in ac	corda	ance	after	thera	apy o	of 3 m	nonth	ns ea	.ch (o	r 1 ma	onth 1	for ritu	uxima	ab)			
		or	0	Ρ	atient atient atient	nas a	plate	elet c	ount	of le:	ss tha	an or	equa	l to 20	0,000	plat	elets	per r	nicro	litre								bleed	ing	
Re-a	sses	ssmei isites Pres Hosp	nt requ (tick l cribec bital.	uire box by	ic thro d after where , or rec equires	6 we app comn	eeks ropria nende	ate) ed by	a ha	aema	tolog	ist, or	r in ac	corda	ance	with	a pro	otocol	l or g	uide	line t	hat ha	as bee	en er	ndorse	ed by	the H	lealth	NZ	
Re-as Prere	sses aqui	ssmei isites Pres Hosp The treat	nt requ (tick I cribec bital. patien ment i	uire Dox I by t ha	d after d after where , or rec as obta equired	12 r app comm lined	nonth ropria nende a res	ate) ed by	a ha se (se	aema ee No	tolog ote) fi	ist, or rom tr	r in ac	ccorda	ance Iuring	with the	initial	appr	-							-			NZ	
Re-a	sses	ssmei isites Pres Hosp	nt requ (tick I cribec bital. Patie	uire Dox by ent	ic thrc d after es who , or red has a munos	3 m ere a comr signi	onths oprop nende icant essive	ed by and e the	y a ha well- rapies	aema docu s hav	itolog iment ve be	ist, or ted co en tria	r in ac ontrair alled a	cordandica and fa	ance tion to ailed	with o spl after	a pro enect	tomy apy o	for c of 3 m	linica	al rea	asons .ch (o	r 1 ma	onth	for ritu	uxima	ab)		NZ	
		or	0	Р	atient atient iucocu	nas i	nmui	ne thi	romb																				Int	

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	PATIENT:							
Name:	Name:							
Ward:	NHI:							
Eltrombopag - continued								
and Hospital.	e with a protocol or guideline that has been endorsed by the Health NZ							
The patient has obtained a response from treatment during the and Patient has maintained a platelet count of at least 50,000 plate and Further treatment with eltrombopag is required to maintain res	elets per microlitre on treatment							
Hospital. and Two immunosuppressive therapies have been trialled and faile and O Patient has severe aplastic anaemia with a platelet count or								
Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a haematologist, or in accordance Hospital. and	e with a protocol or guideline that has been endorsed by the Health NZ t 20,000 platelets per microlitre above baseline during the initial approval luring the initial approval period							

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	PATIENT:								
Name:	Name:								
Ward:	NHI:								
Aluminium chloride									
INITIATION Prerequisites (tick box where appropriate)									
O For use as a haemostatis agent									

and ()

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	PATIENT:								
Name:	Name:								
Ward:	NHI:								
Emicizumab									

INITIATION - Severe Haemophilia A with or without FVIII inhibitors

Prerequisites (tick boxes where appropriate)

()Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and

Patient has severe congenital haemophilia A with a severe bleeding phenotype (endogenous factor VIII activity less than or equal to 2%)

Emicizumab is to be administered at a dose of no greater than 3 mg/kg weekly for 4 weeks followed by the equivalent of 1.5 mg/kg weekly

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:									
Idarucizumab										

INITIATION

Prerequisites (tick box where appropriate)

()For the reversal of the anticoagulant effects of dabigatran when required in situations of life-threatening or uncontrolled bleeding, or for emergency surgery or urgent procedures

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:							
Moroctocog alfa [Recombinant factor VIII]								

INITIATION

Prerequisites (tick box where appropriate)

For patients with haemophilia. Rare Clinical Circumstances Brand of short half-life recombinant factor VIII. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group, subject to criteria ()

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:								
Octocog alfa [Recombinant factor VIII] (Advate)									

INITIATION

Prerequisites (tick box where appropriate)

()For patients with haemophilia. Preferred Brand of short half-life recombinant factor VIII. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group

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:
Octocog alfa [Recombinant factor VIII] (Kogenate FS)	

INITIATION

Prerequisites (tick box where appropriate)

For patients with haemophilia. Rare Clinical Circumstances Brand of short half-life recombinant factor VIII. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group, subject to criteria ()

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:
Nonacog gamma	

INITIATION

Prerequisites (tick box where appropriate)

()For patients with haemophilia. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group

I confirm that the above details are correct	:
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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:	
Rurioctocog alfa pegol [Recombinant factor VIII]		

INITIATION

Prerequisites (tick box where appropriate)

For patients with haemophilia A receiving prophylaxis treatment. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group ()

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:	
Eftrenonacog alfa		

INITIATION

Prerequisites (tick box where appropriate)

For patients with haemophilia B receiving prophylaxis treatment. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group ()

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:	
Factor eight inhibitor bypassing fraction		

INITIATION

Prerequisites (tick box where appropriate)

For patients with haemophilia. Preferred Brand of bypassing agent for > 14 days predicted use. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group ()

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:	
Eptacog alfa		

INITIATION

Prerequisites (tick box where appropriate)

()For patients with haemophilia. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group. Rare Clinical Circumstances Brand of bypassing agent for > 14 days predicted use. Access to funded treatment for > 14 days predicted use is by named patient application to the Haemophilia Treaters Group, subject to access criteria

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.

PRES	CR	IBER	PATIENT:
Name	:		Name:
Ward:			NHI:
Biva	liru	ıdin	
INITI. Prere		ON isites (tick boxes where appropriate)	
	O For use in heparin-induced thrombocytopaenia, heparin resistance or heparin intolerance		
O For use in patients undergoing endovascular procedures			

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:
Danaparoid	
INITIATION Prerequisites (tick box where appropriate)	

O For use in heparin-induced thrombocytopaenia, heparin resistance or heparin intolerance

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.

PRESCR	IBER	PATIENT:
Name:		Name:
Ward:		NHI:
Defibrotide		
INITIATION Prerequisites (tick box where appropriate)		
0	Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	
and	Patient has moderate or severe sinusoidal obstruction syndrome as	a result of chemotherapy or regimen-related toxicities

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:
Fondaparinux sodium	
INITIATION Prerequisites (tick box where appropriate)	

O For use in heparin-induced thrombocytopaenia, heparin resistance or heparin intolerance

()

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	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Lysine acetylsalicylate		
Prerequisites (tick boxes where appropriate)		

 \bigcirc For use when an immediate antiplatelet effect is required prior to an urgent interventional neuro-radiology or interventional cardiology procedure and

Administration of oral aspirin would delay the procedure

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:
Eptif	ibat	ide		
INITIATION Prerequisites (tick boxes where appropriate)				
	or or or	Ο	For use in patients with acute coronary syndromes undergoing	percutaneous coronary intervention
		Ο	For use in patients with definite or strongly suspected intra-coronary thrombus on coronary angiography	
		0	For use in patients undergoing intra-cranial intervention	

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.

PRESCRI	IBER	PATIENT:
Name:		Name:
Ward:		NHI:
Ticagre	lor	
INITIATIO Prerequi	i sites Rest an S	(tick box where appropriate) ricted to treatment of acute coronary syndromes specifically for patients who have recently (within the last 60 days) been diagnosed with T-elevation or a non-ST-elevation acute coronary syndrome, and in whom fibrinolytic therapy has not been given in the last 24 hours and t planned
Re-asses	ON – ssmer	thrombosis prevention neurological stenting th required after 12 months (tick boxes where appropriate)
	or	 O Patient has had a neurological stenting procedure* in the last 60 days O Patient is about to have a neurological stenting procedure performed*
and	d or	 Patient has demonstrated clopidogrel resistance using the P2Y12 (VerifyNow) assay or another appropriate platelet function assay and requires antiplatelet treatment with ticagrelor O Clopidogrel resistance has been demonstrated by the occurrence of a new cerebral ischemic event O Clopidogrel resistance has been demonstrated by the occurrence of transient ischemic attack symptoms referable to the stent.
Re-asses	isites	DN - thrombosis prevention neurological stenting tt required after 12 months (tick boxes where appropriate) Patient is continuing to benefit from treatment Treatment continues to be clinically appropriate
Re-asses	ssmer	Percutaneous coronary intervention with stent deployment ht required after 12 months (tick boxes where appropriate)
and	Ο	Patient has undergone percutaneous coronary intervention Patient has had a stent deployed in the previous 4 weeks Patient is clopidogrel-allergic**
	isites	Stent thrombosis (tick box where appropriate) ent has experienced cardiac stent thrombosis whilst on clopidogrel
Re-asses	ssmer i sites	Myocardial infarction nt required after 1 week (tick box where appropriate) short term use while in hospital following ST-elevated myocardial infarction
l confirm tl	hat th	e 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	PATIENT:
Name:	Name:
Ward:	NHI:

Ticagrelor - continued

Note: Indications marked with * are unapproved indications. Note: Note: ** Clopidogrel allergy is defined as a history of anaphylaxis, urticaria, generalised rash or asthma (in non-asthmatic patients) developing soon after clopidogrel is started and is considered unlikely to be caused by any other treatment

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.

PRESCRIBE	R	PATIENT:
Name:		Name:
Ward:		NHI:
Plerixafor		
Re-assessm Prerequisite	ospital.	nce with a protocol or guideline that has been endorsed by the Health NZ
Patient is to undergo stem cell transplantation and Patient has not had a previous unsuccessful mobilisation attempt with plerixafor and Patient is undergoing G-CSF mobilisation		
	O Has a suboptimal peripheral blood CD34 c treatment O Efforts to collect > 1 × 10 ⁶ CD34 cells/kg ha	count of less than or equal to 10×10^6 /L on day 5 after 4 days of G-CSF ave failed after one apheresis procedure
	or \bigcirc Efforts to collect > 1 × 10 ⁶ CD34 cells/kg has or \bigcirc The peripheral blood CD34 cell counts are	> 5 × 10 ⁹ /L CD34 count of less than or equal to 10×10^{6} /L
	or O A previous mobilisation attempt with G-CSF or G-CSF	plus chemotherapy has failed

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:	
Pegfilgrastim		

INITIATION

Prerequisites (tick box where appropriate)

O For prevention of neutropenia in patients undergoing high risk chemotherapy for cancer (febrile neutropenia risk greater than or equal to 5%*) Note: *Febrile neutropenia risk greater than or equal to 5% after taking into account other risk factors as defined by the European Organisation for Research and Treatment of Cancer (EORTC) guidelines

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:	
Filgrastim		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a haematologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Sodium chloride – Inj	
INITIATION Prerequisites (tick box where appropriate)	
O For use in flushing of in-situ vascular access devices only	

Cardiovascular System

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.

PRES	SCRI	BER		PATIENT:
Name	e:			Name:
Ward:				NHI:
Capt	topi	ril - C	Dral liq 5 mg per ml	
INITI Prer			(tick boxes where appropriate)	
	-		For use in children under 12 years of age	
	or	Ο	For use in tube-fed patients	
	or	Ο	For management of rebound transient hypertension following	cardiac surgery

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.

PRES	SCRIB	ER			PATIENT:
Name	e:				Name:
Ward	Ward:				NHI:
Sacı	ubitri	l w	ith v	valsartan	
	IATIOI equisi		(tick I	boxes where appropriate)	
	(and	С	Patie	ent has heart failure	
	O Patient is in NYHA/WHO functional class II		Patient is in NYHA/WHO functional class II		
		or	Ο	Patient is in NYHA/WHO functional class III	
		or	Ο	Patient is in NYHA/WHO functional class IV	

а	nd			
		or	Ο	Patient has a documented left ventricular ejection fraction (LVEF) of less than or equal to 35%
			Ο	An ECHO is not reasonably practical, and in the opinion of the treating practitioner the patient would benefit from treatment
a	nd (С	Patie	nt is receiving concomitant optimal standard chronic heart failure treatments

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:
Adenosine - Inj 3 mg per ml, 10 ml vial	
INITIATION Prerequisites (tick box where appropriate)	
O For use in cardiac catheterisation, electrophysiology and MRI	

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:
Ajmaline	

Prerequisites (tick box where appropriate)

()Prescribed by, or recommended by a cardiologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

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.

PRES	CRIB	ER		PATIENT:
Name	:			Name:
Ward				NHI:
Ivab	radir	ne		
	ATIOI equis		(tick boxes where appropriate)	
	(and	0	Patient is indicated for computed tomography coronary angiog	Iraphy
	O Patient has a heart rate of greater than 70 beats per minute while taking a maximally tolerated dose of beta blocker or O Patient is unable to tolerate beta blockers			nute while taking a maximally tolerated dose of beta blocker

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:
Midodrine	
INITIATION Prerequisites (tick box where appropriate)	
O Patient has disabling orthostatic hypotension not due to drugs	

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:
Nicardipine hydrochloride	

Prer			(tick boxes where appropriate)
(and	С		cribed by, or recommended by an anaesthetist, intensivist, cardiologist or paediatric cardiologist, or in accordance with a protocol or eline that has been endorsed by the Health NZ Hospital.
		Ο	Patient has hypertension requiring urgent treatment with an intravenous agent
	or	Ο	Patient has excessive ventricular afterload
	or	0	Patient is awaiting or undergoing cardiac surgery using cardiopulmonary bypass

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.

PRES	CRIB	ER			PATIENT:
Name	:				Name:
Ward:					NHI:
Eple	reno	ne			
	ATION equisi		(tick t	poxes where appropriate)	
	(and	С	Patie	ent has heart failure with ejection fraction less than 40%	
		_	Ο	Patient is intolerant to optimal dosing of spironolactone	
		or	0	Patient has experienced a clinically significant adverse e	ffect while on optimal dosing of spironolactone

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:
Talvantan	

Tolvaptan

INITIATION - autosomal dominant polycystic kidney disease Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O 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 O Patient has a confirmed diagnosis of autosomal dominant polycystic kidney disease and O Patient has an estimated glomerular filtration rate (eGFR) of greater than or equal to 25 ml/min/1.73 m² at treatment initiation or O Patient's disease is rapidly progressing, with a decline in eGFR of greater than or equal to 5 mL/min/1.73 m² within one-year or O Patient's disease is rapidly progressing, with an average decline in eGFR of greater than or equal to 2.5 mL/min/1.73 m² per year over a five-year period

CONTINUATION – autosomal dominant polycystic kidney disease Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O 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 O Patient has not developed end-stage renal disease, defined as an eGFR of less than 15 mL/min/1.73 m² O Patient has not undergone a kidney transplant

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:		

Rosuvastatin

INITIATION – cardiovascular disease risk Prerequisites (tick boxes where appropriate)				
		O and O Patient is considered to be at risk of cardiovascular disease Patient is Māori or any Pacific ethnicity		
	or ar	Patient has a calculated risk of cardiovascular disease of at least 15% over 5 years LDL cholesterol has not reduced to less than 1.8 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or simvastatin		
		I – familial hypercholesterolemia tes (tick boxes where appropriate)		
	and (Patient has familial hypercholesterolemia (defined as a Dutch Lipid Criteria score greater than or equal to 6) LDL cholesterol has not reduced to less than 1.8 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or simvastatin 		
		I – established cardiovascular disease tes (tick boxes where appropriate)		
		or O Patient has proven coronary artery disease (CAD) or O Patient has proven peripheral artery disease (PAD) or O Patient has experienced an ischaemic stroke		
	and	D LDL cholesterol has not reduced to less than 1.4 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or simvastatin		
	NITIATION – recurrent major cardiovascular events Prerequisites (tick boxes where appropriate)			
	and	Patient has experienced a recurrent major cardiovascular event (defined as myocardial infarction, ischaemic stroke, coronary revascularisation, hospitalisation for unstable angina) in the last 2 years		

LDL cholesterol has not reduced to less than 1.0 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or

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:		
Levosimendan			
INITIATION – Heart transplant Prerequisites (tick boxes where appropriate) O For use as a bridge to heart transplant, in patients who have boots or O For the treatment of heart failure following heart transplant	been accepted for transplant		
INITIATION – Heart failure Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by a cardiologist or intensivist, or in Health NZ Hospital.	accordance with a protocol or guideline that has been endorsed by the		

O For the treatment of severe acute decompensated heart failure that is non-responsive to dobutamine

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.

PRES	SCRIBER	PATIENT:
Name	9:	Name:
Ward	:	NHI:
Alpr	ostadil	
	IATION equisites (tick boxes where appropriate)	
	O Patient has erectile dysfunction	
	Patient is to receive a penile Doppler ultrasonography	
	and	

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:		
Hydı	rala	zine	hydrochloride - Tab 25 mg			
INITI Prer			(tick boxes where appropriate)			
O For the treatment of refractory hypertension						
	or	0	For the treatment of heart failure, in combination with a nitrate and/or angiotensin receptor blockers	, in patients who are intolerant or have not responded to ACE inhibitors		

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:			
bosentan				
INITIATION – PAH monotherapy Re-assessment required after 6 months				
Prerequisites (tick boxes where appropriate)				
O Prescribed by, or recommended by a respiratory specialist, cardiolo a respiratory specialist, cardiologist or rheumatologist, or in accorda Hospital	gist, rheumatologist or any relevant practitioner on the recommendation of nce with a protocol or guideline that has been endorsed by the Health NZ			

and) Ра	atient has pulmonary arterial hypertension (PAH)*
C) р	AH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications
and and) р/	AH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
		O PAH has been confirmed by right heart catheterisation
		and O A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair) and
		O A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg
		and O Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵) and
		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
	or (or	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	(and	D Bosentan is to be used as PAH monotherapy
		O Patient has experienced intolerable side effects on sildenafil
		or O Patient has an absolute contraindication to sildenafil
		or O Patient is a child with idiopathic PAH or PAH secondary to congenital heart disease
C		

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	PATIENT:			
Jame: Name:				
Ward: NHI:				
bosentan - co	ntinued			
Re-assessment Prerequisites (t	AH dual therapy required after 6 months ick boxes where appropriate) ibed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of iratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ al.			
and O F and	Patient has pulmonary arterial hypertension (PAH)* PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, 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 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) † Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool** Patient has PAH other than idiopathic / heritable or drug-associated type 			
or and	 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	 Bosentan is to be used as part of PAH dual therapy Patient has tried a PAH monotherapy (sildenafil) for at least three months and has experienced an inadequate therapeutic response to treatment according to a validated risk stratification tool** Patient is presenting in NYHA/WHO functional class III or IV, and in the opinion of the treating clinician would likely benefit from initial dual therapy 			

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.

PRES	CRIB	ER		PATIENT:
Name	ame: Name:			
Ward:				NHI:
bose	ntar) - co	ntinue	d
INITI Re-as	ATION ssess equisi	N - PA ment ites (t Prescrit lospita lospita	AH trip require ick boo bed b ratory al. Patient Patient PAH is and and	De therapy ad after 6 months xes where appropriate) y, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ : has pulmonary arterial hypertension (PAH)* in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV 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 Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵)
	and	or or		 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) † Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool** 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 contan circulation requiring the minimising of pulmonary/venous filling pressures Bosentan is to be used as part of PAH triple therapy
		and	or	 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** Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario

Page 90

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.

PATIENT:				
NHI:				
CONTINUATION Re-assessment required after 2 years				
appropriate)				
ommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of st, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ				
2 years appropriate) ommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of				

O Patient is continuing to derive benefit from bosentan 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.

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:

Ambrisentan

	INITIATION – PAH monotherapy Re-assessment required after 6 months				
Prer	equisi	ites (t	ick bo	exes where appropriate)	
(and	O 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	D f	Patier	t has pulmonary arterial hypertension (PAH)	
)	J f	PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications		
	and (and) f	PAH is	s in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV	
			and	O PAH has been confirmed by right heart catheterisation	
				O A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)	
			anc	O A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg	
			and	O Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵)	
				O 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	
		or or		Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including 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				
		and	\mathbf{O}	Ambrisentan is to be used as PAH monotherapy	
			or	O Patient has experienced intolerable side effects with both sildenafil and bosentan	
				O Patient has an absolute contraindication to sildenafil and an absolute or relative contraindication to bosentan (e.g. due to current use of a combined oral contraceptive or liver disease)	
			or	O Patient is a child with idiopathic PAH or PAH secondary to congenital heart disease	
		\square	_	()	

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.

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:
Ambrisentan - continued	
	months
O Patient has pulm	onary arterial hypertension (PAH)
and	1, 4 or 5 of the WHO (Venice 2003) clinical classifications ork Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
and A me and A pulm and O A pulm and O C O C O C O C O C O C O C O C	has been confirmed by right heart catheterisation ean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair) Imonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg nonary 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) † Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool** Patient has PAH other than idiopathic / heritable or drug-associated type
and	an is to be used as PAH triple therapy ent is on the lung transplant list Patient is presenting in NYHA/WHO functional class IV Patient has an absolute or relative contraindication to bosentan (e.g. due to current use of a combined oral contraceptive or liver disease)
and	Patient has tried PAH dual therapy for at least three months and remains in an unacceptable risk category according to a validated risk stratification tool** Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario

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	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Ambrisentan - continued			
	gist, rheumatologist or any relevant practitioner on the recommendation of nce with a protocol or guideline that has been endorsed by the Health NZ nt according to a validated PAH risk stratification tool**		
Note: † The European Respiratory Journal Guidelines can be found here: <u>2022 ECS/ERS Guidelines for the</u> <u>diagnosis and treatment of pulmonary hypertension PAH</u> ** 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.			

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:

sildenafil (Vedafil)

	tes (tick boxes where appropriate) D Patient has Raynaud's phenomenon
and (Patient has severe digital ischaemia (defined as severe pain requiring hospital admission or with a high likelihood of digital ulceration; digital ulcers; or gangrene)
and (Patient is following lifestyle management (proper body insulation, avoidance of cold exposure, smoking cessation support, avoidance of sympathomimetic drugs)
and (Patient has persisting severe symptoms despite treatment with calcium channel blockers and nitrates (unless contraindicated or not tolerated)
	I – tablets Pulmonary arterial hypertension tes (tick boxes where appropriate)

\cup		cardiologist, rheumatologist or any relevant practitioner on the recommendation or
		accordance with a protocol or guideline that has been endorsed by the Health NZ
and	Hospital.	

nd	O Patient has pulmonary arterial hypertension (PAH)*				
		nd O PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications			
and O PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV and					
		O PAH is confirmed by right heart catheterisation			
		A mean pulmonary artery pressure (PAPm) of greater than 20 mmHg			
		O A pulmonary capillary wedge pressure (PCWP) that is less than or equal to 15 mmHg			
		and O Pulmonary vascular resistance (PVR) of at least 2 Wood Units or at least 160 International Units (dyn s cm ⁻⁵) and			
		O PAH is 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) †			
		or 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			
c		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			
	or	O 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			

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:	
silde	nafi	l (Ve	edafil) - continued	
			tablets other conditions (tick boxes where appropriate)	
	(or	С	For use in weaning patients from inhaled nitric oxide	
	(or	О	For perioperative use in cardiac surgery patients	
	(С	For use in intensive care as an alternative to nitric oxide	
	or (С	For use in the treatment of erectile dysfunction secondary to spinal cord injury in patients being treated in a spinal unit	J
INITIATION – injection Prerequisites (tick boxes where appropriate)				
For use in the treatment of pulmonary hypertension in infants or children being treated in paediatric intension intensive care units when the enteral route is not accessible		For use in the treatment of pulmonary hypertension in infants or children being treated in paediatric intensive care units and neonatal intensive care units when the enteral route is not accessible		
			O For perioperative use following cardiac surgery	
		or or	O For use in persistent pulmonary hypertension of the newborn (PPHN)	
			O For use in congenital diaphragmatic hernia	
				J

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.

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

Re-a	sses	smen	t require	al therapy ed after 6 months kes where appropriate)
O Prescribed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recomme a respiratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Hospital.				
	and		Patient	has pulmonary arterial hypertension (PAH)
	and	Ο	PAH is	in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications
	and	Ο	PAH is	in New York Heart Association/World Health Organization (NYHA/WHO) functional class III or IV
			(O PAH has been confirmed by right heart catheterisation
			and (and	O A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)
			and (O 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) and		m O A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵)	
				O 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
	or O Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmen disorders including severe chronic neonatal lung disease		Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung isorders including severe chronic neonatal lung disease	
				Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the contan circulation requiring the minimising of pulmonary/venous filling pressures
	and		\bigcirc	
	O Epoprostenol is to be used as part of PAH dual therapy with either sildenafil or an endothelin receptor antagonist and O Patient is presenting in NYHA/WHO functional class IV			
		and	Оr	Patient has tried a PAH monotherapy for at least three months and remains in an unacceptable risk category according to a alidated risk stratification tool

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				
Epoprositeriol - continued INITIATION – PAH triple therapy Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation a respiratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health 1 Hospital. and Patient has pulmonary arterial hypertension (PAH) and PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications and PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class III or IV and A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair) and A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg and A pulmonary vascular resistance greater than 20 word Units or greater than 160 International Units (dyn s cm ⁻⁵) and 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) † Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool ^{**}				
disorders including severe chronic neonatal lung disea	disease and elevated pulmonary pressures or a major complication of the			
and Epoprostenol is to be used as PAH triple therapy and O Patient is on the lung transplant list or O Patient is presenting in NYHA/WHO functional c or O Patient has tried PAH dual therapy for at la treatment according to a validated risk stra	east three months and has not experienced an acceptable response to			

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	
	gist, rheumatologist or any relevant practitioner on the recommendation of ince with a protocol or guideline that has been endorsed by the Health NZ ccording to a validated PAH risk stratification tool
Note: † The European Respiratory Journal Guidelines can be found here: diagnosis and treatment of pulmonary hypertension PAH ** the requirement to use a validated risk stratification tool to determine ins Determining insufficient response in children does not require use of a validat currently no such validated tools exist for PAH risk stratification in children.	ufficient response applies to adults.

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.

RESCRIE	BER														P/	ATIE	NT:																	
ame:															Na	ame:																		
lard:															N	ні: .																		
oprost																																		
NITIATIO Re-assess Prerequis	ON – P, sment sites († Prescr a resp Hospit	requiritick bo ribed b iratory al. Patient PAH is PAH is and and and and and and and and	ad aftwares w w, or ru- special has p in Gr in Ne O O or or or atien isordu	er 6 n here ecom allist, ulmo oup 1 w Yo PAH I A me A pull A pull O O O O I is a ers in has	pppr men card mary 4 c k Hi as I n p non PAH defi Pati risk Pati child clud	opria ded I iolog r arte r 5 o eart / oeen ulmo ary c ary v l has ned i ent h strati ent h strati	by a list or arial h f the Assoce confi nary apilla ascul beer n the as no ficati as PAH evere singli	when when when ciatio arter arter arter arter 202 ot ex jon to AH o	uma rtens O (V on/W d by ry pr redge esista mon 2 EC periodo onic cond onic ntric	sion (/enice Vorld / right ressu e pre ance mstrate CS/E	(PAH (PAH ee 200 I Hea ure (I essur e grea ted to ERS (ed an n idic ed an n idic conata	or in A H) 03) c alth O art ca PAPn re (P0 ater t c be r Guide n acco ngen al lung nital l	acco	rdai al cla izati erisa eate) le: 2 W espo s fou ble r eare ease c dis	ass ion atio er th ss 1 ood ons r P/ esp able t di	e or of siseas se ar	tions HA/V or e its o in vasee i e to drug	wHu equa or grunote calco g-as: r PA	IO) 1 IO) 1 Ig (u al to reate cium ssoc	fun unle o 15 cert ctivi m a ciate	r gu nctio 5 m tha rity w fo anta ed e to	ide ona mH asspe r li ago typ	I cla eri Fo Ig 60 li sess nk to nist e	ss I onta mer o the trea	i ha I, II nati nt us ese atme	s be	IV r) I Un ilop delir acco	its ((prost nes) prdir	dyn or r † ng to eve	s cm hitric	n ⁻⁵) oxide alidat	e, as	h N.	
	and) C	Patier	t ha	s exp	perier	nced	l into	other olerat	ble s			s or	ı sil	lden;	afil a	and	botl	h th	hei	fune	ded	enc	loth	elin	rece	epto	r an	tago	nists	(i.e.		

Patient has an absolute contraindication to sildenafil and an absolute or relative contraindication to endothelin receptor antagonists

()

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.

PRESCR	IBER		PATIENT:
Name:			Name:
Nard:			NHI:
loprost	t - cont	tinued	
Re-asses	ssment isites (Prescr a resp Hospit	requir tick bc ibed b iratory al. Patien PAH is	<pre>ial therapy red after 6 months pixes where appropriate) py, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of propriate, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ it has pulmonary arterial hypertension (PAH) s in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications s in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV</pre>
an	-	and and and	 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)
an	or or d and	0	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	or	 Patient has an absolute of relative contraindication to of experienced intolerable side enects with a funded endotrient receptor antagonist 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** Patient is presenting in NYHA/WHO functional class III or IV, and in the opinion of the treating clinician would benefit from initial dual therapy

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.

PRES	CRIB	ER				PATIENT:
Name	:					Name:
Ward:						NHI:
llopro	ost -	conti	nued			
INITI/ Re-as	ATION ssessi equisi D P a	N - PAment i tes (ti rescri respin lospita	AH trij requir reduir bed b bed b ratory al. Patien PAH is and and and and and	ed af xes v y, or spec t has in G in N O O O O O O O O O O O O O O O O O O O	where recom cialist, a pulmo aroup 1 lew Yo PAH A me A pul A pul O O O O	nonths appropriate) Immended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ onary arterial hypertension (PAH) II, 4 or 5 of the WHO (Venice 2003) clinical classifications rrk Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV has been confirmed by right heart catheterisation an pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair) monary capillary wedge pressure (PCWP) less than or equal to 15 mmHg monary 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) † Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool** Patient has PAH other than idiopathic / heritable or drug-associated type child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung including severe chronic neonatal lung disease
	and					palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the ulation requiring the minimising of pulmonary/venous filling pressures
	and	(and	or or	lopro O and	Patie Patie	o be used as PAH triple therapy Int is on the lung transplant list Int 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** Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative
		,			_	scenario

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.

PRESCR	IBER	PATIENT:					
Name:		Name:					
Ward:		NHI:					
lloprost	- continued						
	CONTINUATION Re-assessment required after 2 years						
Prerequ	isites (tick box where appropriate)						
O	Prescribed by, or recommended by a respiratory specialist, cardiolog a respiratory specialist, cardiologist or rheumatologist, or in accorda Hospital.	gist, rheumatologist or any relevant practitioner on the recommendation of nce with a protocol or guideline that has been endorsed by the Health NZ					
and	Patient is continuing to derive benefit from iloprost treatment according	ing 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.

Dermatologicals

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:
Mafenide acetate	
INITIATION Prerequisites (tick box where appropriate)	
O For the treatment of burns patients	

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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:
Betamethasone valerate with clioquinol	
INITIATION Prerequisites (tick boxes where appropriate)	
O For the treatment of intertrigo	
O For continuation use	

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:
Pimecrolimus	

Prer	equisites	(tick boxes where appropriate)
(and		cribed by, or recommended by a dermatologist, paediatrician or ophthalmologist, or in accordance with a protocol or guideline that has been rsed by the Health NZ Hospital.
	and	Patient has atopic dermatitis on the eyelid
		Patient has at least one of the following contraindications to topical corticosteroids: periorificial dermatitis, rosacea, documented epidermal atrophy, documented allergy to topical corticosteroids, cataracts, glaucoma, or raised intraocular pressure

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:	
Ta ana lina an Oin Incan I		

Tacrolimus Ointment

(

INITIATION

and

Prerequisites (tick boxes where appropriate)

()Prescribed by, or recommended by a dermatologist or paediatrician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

 \bigcirc Patient has atopic dermatitis on the face and

Patient has at least one of the following contraindications to topical corticosteroids: periorificial dermatitis, rosacea, documented epidermal atrophy or documented allergy to topical corticosteroids

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:		
Methyl aminolevulinate hydrochloride			

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a dermatologist or plastic surgeon, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

Genito-Urinary System

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:
Terbutaline	

Prerequisites (tick box where appropriate)

()Prescribed by, or recommended by an obstetrician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

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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.

PRES	CRIB	ER		PATIENT:
Name	:			Name:
Ward:				NHI:
Finas	steri	de		
INITI. Prere			(tick boxes where appropriate)	
	(and	С	Patient has symptomatic benign prostatic hyperplasia	
	O The patient is intolerant of non-selective alpha blockers or these are contraindicated or			
			O Symptoms are not adequately controlled with non-select	tive alpha blockers

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.

PRES	CRIBER		PATIENT:
Name	:		Name:
Ward:			NHI:
Tams	sulosin		
	ATION equisites	(tick boxes where appropriate)	
	and	Patient has symptomatic benign prostatic hyperplasia	
	<u> </u> O	The patient is intolerant of non-selective alpha blockers or the	se are contraindicated

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:	
Potassium citrate		
INITIATION Prerequisites (tick boxes where appropriate)		
O The patient has recurrent calcium oxalate urolithiasis and		
O The patient has had more than two renal calculi in the two years	ars prior to the application	

Hormone Preparations

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:
Oxandroline - Tab 2.5 mg	
INITIATION Prerequisites (tick box where appropriate)	
O For the treatment of burns patients	

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.	

PRESCR	BER	PATIENT:	
Name:		Name:	
Ward:		NHI:	
Cinacal	cet		
Re-asses	DN – parathyroid carcinoma or calcip ssment required after 6 months sites (tick boxes where appropriate) Prescribed by, or recommended by a r the Health NZ Hospital.	phylaxis hephrologist or endocrinologist, or in accordance with a protocol or guideline that has been endorsed by	
or	and O The patient has persistent	nosed with a parathyroid carcinoma (see Note) hypercalcaemia (serum calcium greater than or equal to 3 mmol/L) despite previous first-line m thiosulfate (where appropriate) and bisphosphonates	
	 The patient has been diagnosed with calciphylaxis (calcific uraemic arteriolopathy) and The patient has symptomatic (e.g. painful skin ulcers) hypercalcaemia (serum calcium greater than or equal to 3 mmol/L) and The patient's condition has not responded to previous first-line treatments including bisphosphonates and sodium thiosulfate 		
	the Health NZ Hospital.	hephrologist or endocrinologist, or in accordance with a protocol or guideline that has been endorsed by	
The patient has experienced clinically significant symptom improvement			
Note: Th	is does not include parathyroid adenon	has unless these have become malignant.	
	DN – primary hyperparathyroidism sites (tick boxes where appropriate)		
an	O Patient has primary hyperparath	yroidism	
	O Patient has hypercalcaemia of more than 3 mmol/L with or without symptoms or O Patient has hypercalcaemia of more than 2.85 mmol/L with symptoms		
and O Surgery is not feasible or has failed and			

O Patient has other comorbidities, severe bone pain, or calciphylaxis

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:
Cinacalcet - continued	
INITIATION – secondary or tertiary hyperparathyroidism Re-assessment required after 6 months	
Prerequisites (tick boxes where appropriate)	
O Patient has tertiary hyperparathyroidism and markedly e	elevated parathyroid hormone (PTH) with hypercalcaemia

	Patient has symptomatic secondary hyperparathyroidism and elevated PTH
and	Patient is on renal replacement therapy
	O Residual parathyroid tissue has not been localised despite repeat unsuccessful parathyroid explorations
	or O Parathyroid tissue is surgically inaccessible
	O Parathyroid surgery is not feasible

CONTINUATION – secondary or tertiary hyperparathyroidism Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

()

or

The patient has had a kidney transplant, and following a treatment free interval of at least 12 weeks a clinically acceptable parathyroid hormone (PTH) level to support ongoing cessation of treatment has not been reached

The patient has not received a kidney transplant and trial of withdrawal of cinacalcet is clinically inappropriate

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	PATIENT:
Name:	Name:
Ward:	NHI:
Cabergoline	
INITIATION Prerequisites (tick boxes where appropriate) O Inhibition of lactation or O Patient has hyperprolactinemia or O Patient has acromegaly	
Note: Indication marked with * is an unapproved indication.	

RS1826 - Somatropin	
Prader-Willi syndrome - INITIATION	125
Prader-Willi syndrome - CONTINUATION Turner syndrome - INITIATION	122
Turner syndrome - CONTINUATION Adults and adolescents - INITIATION	126
Adults and adolescents - CONTINUATION Growth hormone deficiency in children - INITIATION	127
Growth hormone deficiency in children - CONTINUATION Short stature due to chronic renal insufficiency - INITIATION	
Short stature due to chronic renal insufficiency - CONTINUATION	124
Short stature without growth hormone deficiency - INITIATION	

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		ER PATIENT:		
Name: Name:		Name:		
Ward:		NHI:		
Som	atro	pin		
Re-a	ssess equis	N – growth hormone deficiency in children iment required after 12 months ites (tick boxes where appropriate) Prescribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
	or	 Growth hormone deficiency causing symptomatic hypoglycaemia, or with other significant growth hormone deficient sequelae (e.g. cardiomyopathy, hepatic dysfunction) and diagnosed with GH < 5 mcg/l on at least two random blood samples in the first 2 weeks of life, or from samples during established hypoglycaemia (whole blood glucose < 2 mmol/l using a laboratory device) Height velocity < 25th percentile for age; and adjusted for bone age/pubertal status if appropriate over 6 or 12 months using the standards of Tanner and Davies (1985) A current bone age is < 14 years (female patients) or < 16 years (male patients) Peak growth hormone value of < 5.0 mcg per litre in response to two different growth hormone stimulation tests. In children who are 5 years or older, GH testing with sex steroid priming is required If the patient has been treated for a malignancy, they should be disease free for at least one year based upon follow-up laboratory and radiological imaging appropriate for the malignancy, unless there are strong medical reasons why this is either not necessary or appropriate Appropriate imaging of the pituitary gland has been obtained 		
		ATION – growth hormone deficiency in children ment required after 12 months		
Prere	equis	ites (tick boxes where appropriate)		
(and		Prescribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
	(and	O A current bone age is 14 years or under (female patients) or 16 years or under (male patients)		
		 Height velocity is greater than or equal to 25th percentile for age (adjusted for bone age/pubertal status if appropriate) while on growth hormone treatment, as calculated over six months using the standards of Tanner and Davis (1985) Height velocity is greater than or equal to 2.0 cm per year, as calculated over 6 months 		
	and (O No serious adverse effect that the patients specialist considers is likely to be attributable to growth hormone treatment has occurred		
	and O No malignancy has developed since starting growth hormone			
Re-a Prere	ssess equis C F	N – Turner syndrome iment required after 12 months ites (tick boxes where appropriate) Prescribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
and	(and	 The patient has a post-natal genotype confirming Turner Syndrome Height velocity is < 25th percentile over 6-12 months using the standards of Tanner and Davies (1985) 		

O A current bone age is < 14 years

I confirm that the above details are correct:

and

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	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Somatropin - continued		
CONTINUATION – Turner syndrome Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by an endocrinologist or paediatric endorsed by the Health NZ Hospital. and	endocrinologist, or in accordance with a protocol or guideline that has been	
and endorsed by the Health NZ Hospital. The patient's height is more than 3 standard deviations below or delay and Height velocity is < 25th percentile for age (adjusted for bone a using the standards of Tanner and Davies(1985) and A current bone age is < 14 years (female patients) or < 16 year and	endocrinologist, or in accordance with a protocol or guideline that has been the mean for age or for bone age if there is marked growth acceleration age/pubertal status if appropriate), as calculated over 6 to 12 months ars (male patients) valignancy or recognized severe skeletal dysplasia) and is not receiving	
CONTINUATION – short stature without growth hormone deficiency Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
12 months using the standards of Tanner and Davies (1985) and Height velocity is greater than or equal to 2 cm per year as calc and Current bone age is 14 years or under (female patients) or 16 and		

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 th	e Pharmaceutical
Schedule. For community funding, see the Special Authority Criteria.			

PRESCRIBER	PATIENT:			
Name:	Name:			
Ward: NHI:				
Somatropin - continued				
INITIATION – short stature due to chronic renal insufficiency Re-assessment required after 12 months				
Prerequisites (tick boxes where appropriate)				
 Prescribed by, or recommended by an endocrinologist, paediatric e or paediatric endocrinologist, or in accordance with a protocol or gu and 	ndocrinologist or renal physician on the recommendation of a endocrinologist ideline that has been endorsed by the Health NZ Hospital.			
O The patient's height is more than 2 standard deviations below and	v the mean			
standards of Tanner and Davies (1985)	bertal status if appropriate) as calculated over 6 to 12 months using the			
A current bone age is to 14 years or under (female patients) of and	or to 16 years or under (male patients)			
O The patient is metabolically stable, has no evidence of metab	olic bone disease and absence of any other severe chronic disease			
The patient is under the supervision of a specialist with exper	tise in renal medicine			
O The patient has a GFR less than or equal to 30 ml/min. creatinine (umol/l × 40 = corrected GFR (ml/min/1.73 m	/1.73 m ² as measured by the Schwartz method (Height(cm)/plasma ²) in a child who may or may not be receiving dialysis			
	seived < 5mg/ m ² /day of prednisone or equivalent for at least 6 months			
CONTINUATION – short stature due to chronic renal insufficiency Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)				
 Prescribed by, or recommended by an endocrinologist, paediatric e or paediatric endocrinologist, or in accordance with a protocol or guand 	ndocrinologist or renal physician on the recommendation of a endocrinologist ideline that has been endorsed by the Health NZ Hospital.			
Height velocity is greater than or equal to 50th percentile (adj 12 months using the standards of Tanner and Davies (1985)	usted for bone age/pubertal status if appropriate) as calculated over 6 to			
And O Height velocity is greater than or equal to 2 cm per year as ca	alculated over six months			
A current bone age is 14 years or under (female patients) or	16 years or under (male patients)			
And O No serious adverse effect that the patients specialist consider and	rs is likely to be attributable to growth hormone has occurred			
O No malignancy has developed after growth hormone therapy	was commenced			
The patient has not experienced significant biochemical or m	etabolic deterioration confirmed by diagnostic results			
The patient has not received renal transplantation since starti	ing growth hormone treatment			
\sim	iption should cease before transplantation and a new application should			

Use this checklist to determine if a patient meets the restrictions for funding in th Schedule. For community funding, see the Special Authority Criteria.	e hospital setting. For more details, refer to Section H of the Pharmaceutical
concurs. For community funding, see the opecial Authority Official.	
PRESCRIBER	ΡΔΤΙΕΝΤ·

THEOORDER		
Name:	Name:	
Ward: NHI:		
Somatropin - continued		
	aediatric endocrinologist, or in accordance with a protocol or guideline that has been	
and	that has been confirmed by genetic testing or clinical scoring criteria	
	< 16 years (male patients) med and there is no obstructive sleep disorder requiring treatment, or if an nately treated under the care of a paediatric respiratory physician and/or ENT	
and O The patient is aged two years or older and O There is no evidence of type II diabetes or	r uncontrolled obesity defined by BMI that has increased by greater than or	
or O The patient is aged between six months and two prior to treatment commencement and at six to the prior to treatment commencement and at six to the prior to treatment commencement and the prior to treatment and the prior to t	o years and a thorough upper airway assessment is planned to be undertaken	
CONTINUATION – Prader-Willi syndrome Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)		
and O Height velocity is greater than or equal to 50th percent 12 months using the standards of Tanner and Davies	aediatric endocrinologist, or in accordance with a protocol or guideline that has been tile (adjusted for bone age/pubertal status if appropriate) as calculated over 6 to (1985)	
and O Height velocity is greater than or equal to 2 cm per yea and	ar as calculated over six months	

 ${\cal J}\,$ A current bone age is 14 years or under (female patients) or 16 years or under (male patients)

D No serious adverse effect that the patient's specialist con siders is likely to be attributable to growth hormone treatment has occurred

No malignancy has developed after growth hormone therapy was commenced

The patient has not developed type II diabetes or uncontrolled obesity as defined by BMI that has increased by greater than or equal to 0.5 standard deviations in the preceding 12 months

and

and

and

()

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:		
Somatropin - continued			
INITIATION – adults and adolescents Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)			
O Prescribed by, or recommended by an endocrinologist or paediatric endorsed by the Health NZ Hospital.	endocrinologist, or in accordance with a protocol or guideline that has been		
treatment of a pituitary tumour)	owth hormone deficiency (e.g. surgical removal of the pituitary for		
The patient has undergone appropriate treatment of other hor	nonal deficiencies and psychological illnesses		
O The patient has severe growth hormone deficiency (see notes	The patient has severe growth hormone deficiency (see notes)		
O The patient's serum IGF-I is more than 1 standard deviation b	The patient's serum IGF-I is more than 1 standard deviation below the mean for age and sex		
The patient has poor quality of life, as defined by a score of 16 or more using the disease-specific quality of life questionnaire for adult growth hormone deficiency (QoL-AGHDA®)			
Note: For the purposes of adults and adolescents, severe growth hormone de equal to 3 mcg per litre during an adequately performed insulin tolerance test. Patients with one or more additional anterior pituitary hormone deficiencies ar isolated growth hormone deficiency require two growth hormone stimulation te an additional test is required, an arginine provocation test can be used with a	(ITT) or glucagon stimulation test. d a known structural pituitary lesion only require one test. Patients with ests, of which, one should be ITT unless otherwise contraindicated. Where		

The dose of somatropin should be started at 0.2 mg daily and be titrated by 0.1 mg monthly until it is within 1 standard deviation of the mean normal value for age and sex; and

The dose of somatropin not to exceed 0.7 mg per day for male patients, or 1 mg per day for female patients. At the commencement of treatment for hypopituitarism, patients must be monitored for any required adjustment in replacement doses of corticosteroid and levothyroxine.

I confirm that the above details are	e correct:
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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:	Nard:			NHI:
Soma	atro	pin - con	tinued	
Re-as	ssess equis	ment requ ites (tick b Prescribed	dults and adolescents irred after 12 months boxes where appropriate) by, or recommended by an endocrinologist or paediatric e by the Health NZ Hospital.	endocrinologist, or in accordance with a protocol or guideline that has been
		and	The patient has been treated with somatropin for < 12 n	nonths
		and	There has been an improvement in the Quality of Life As Life Assessment of Growth Hormone Deficiency in Adult	ssessment defined as a reduction of at least 8 points on the Quality of s (QoL-AGHDA®) score from baseline
		and	Serum IGF-I levels have increased to within ± 1 SD of the	mean of the normal range for age and sex
			The dose of somatropin does not exceed 0.7 mg per day	y for male patients, or 1 mg per day for female patients
	or			
		and	The patient has been treated with somatropin for more the	han 12 months
		O	The patient has not had a deterioration in Quality of Life score on treatment (other than due to obvious external fa	defined as a 6 point or greater increase from their lowest QoL-AGHDA® actors such as external stressors)
		and	Serum IGF-I levels have continued to be maintained with for obvious external factors)	nin ± 1 SD of the mean of the normal range for age and sex (other than
		and	The dose of somatropin has not exceeded 0.7 mg per da	ay for male patients or 1 mg per day for female patients
	or			
		and	The patient has had a Special Authority approval for son renewal criteria under this indication	natropin for childhood deficiency in children and no longer meets the
		and	The patient has undergone appropriate treatment of othe	er hormonal deficiencies and psychological illnesses
	O The patient has severe growth hormone deficiency (see notes) and			
	The patient's serum IGF-I is more than 1 standard deviation below the mean for age and sex			tion below the mean for age and sex
		0	The patient has poor quality of life, as defined by a score for adult growth hormone deficiency (QoL-AGHDA®)	e of 16 or more using the disease-specific quality of life questionnaire
equal	l to 3	mcg per lit	tre during an adequately performed insulin tolerance test	ficiency is defined as a peak serum growth hormone level of less than or (ITT) or glucagon stimulation test. In a known structural pituitary lesion only require one test. Patients with

reatients with one or more additional anterior pitultary hormone delicercles and a known structural pitultary lesion only require one test. Patients with isolated growth hormone deficiency require two growth hormone stimulation tests, of which, one should be ITT unless otherwise contraindicated. Where an additional test is required, an arginine provocation test can be used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre. The dose of somatropin should be started at 0.2 mg daily and be titrated by 0.1 mg monthly until the serum IGF-I is within 1 standard deviation of the mean normal value for age and sex; and

The dose of somatropin not to exceed 0.7 mg per day for male patients, or 1 mg per day for female patients.

At the commencement of treatment for hypopituitarism, patients must be monitored for any required adjustment in replacement doses of corticosteroid and levothyroxine.

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:	
Liothyronine sodium - Tab 20 mcg		

Prerequisites (tick box where appropriate)

m O~ For a maximum of 14 days' treatment in patients with thyroid cancer who are due to receive radioiodine therapy

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.

PRES	CRIBER	PATIENT:
Name:		Name:
Ward:		NHI:
Prop	ylthiouracil	
	ATION equisites (tick boxes where appropriate)	
	O The patient has hyperthyroidism	
	The patient is intolerant of carbimazole or carbimazole is cont	raindicated

Infections

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:
Streptomycin sulphate	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	
Amikacin		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Tobramycin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Tobramycin Solution for inhalation 60 mg per ml, 5 ml	
INITIATION Prerequisites (tick box where appropriate)	
O Patient has cystic fibrosis	

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:
Tobramcyin	
INITIATION Prerequisites (tick box where appropriate)	
O For addition to orthopaedic bone cement	

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:
Paromomycin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or gastroenterologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	
Imipenem with cilastatin		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Ertapenem	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Meropenem	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Ceftazadime	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Cefepime	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Ceftaroline	
INITIATION – multi-resistant organisn salvage therapy Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	
O For patients where alternative therapies have failed	
O For patients who have a contraindication or hypersensitivity to	standard current therapies

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:
Roxithromycin tab dispersible 50 mg	
INITIATION Prerequisites (tick box where appropriate)	
O Only for use in patients under 12 years of age	

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:	
Clarithromycin		
INITIATION – Tab 250 mg and oral liquid Prerequisites (tick boxes where appropriate) O Atypical mycobacterial infection or O or Helicobacter pylori eradication or Prophylaxis of infective endocarditis associated with surgical of the		
INITIATION - Tab 500 mg Prerequisites (tick box where appropriate) O Helicobacter pylori eradication		
INITIATION – Infusion Prerequisites (tick boxes where appropriate)		

or O Mycobacterium tuberculosis infection where there is drug resistance or intolerance to standard pharmaceutical agents

O Community-acquired pneumonia

Atypical mycobacterial infection

 \bigcirc

or

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:	
Azithromycin		
INITIATION – bronchiolitis obliterans syndrome, cystic fibrosis and atyperequisites (tick boxes where appropriate)	oical Mycobacterium infections	
obliterans syndrome* or O Patient has received a lung transplant and requires prophylax or	t bone marrow transplant and requires treatment for bronchiolitis tis for bronchiolitis obliterans syndrome* udomonas aeruginosa or Pseudomonas related gram negative organisms*	
	atrician, or in accordance with a protocol or guideline that has been	
and endorsed by the Health NZ Hospital. O For prophylaxis of exacerbations of non-cystic fibrosis bronch and O Patient is aged 18 and under and O Patient has had 3 or more exacerbations of their bronc O Patient has had 3 acute admissions to hospital for treat		
Note: Indications marked with * are unapproved indications. A maximum of in the community.	24 months of azithromycin treatment for non-cystic fibrosis will be subsidised	
and endorsed by the Health NZ Hospital.	eceived any further azithromycin treatment for non-cystic fibrosis nically inappropriate to stop treatment zithromycin cumulative treatment (see note)	
INITIATION – other indications Re-assessment required after 5 days Prerequisites (tick box where appropriate)		

O For any other condition

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	PATIENT:
Name:	Name:
Ward:	NHI:
Azithromycin - continued	
CONTINUATION – other indications Re-assessment required after 5 days Prerequisites (tick box where appropriate)	
O For any other condition	

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:	
Ticarcillin with clavulanic acid		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	
Piperacillin with tazobactam		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Ciprofloxacin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:

Moxifloxacin

			cobacterium infection :k boxes where appropriate)
and			bed by, or recommended by an infectious disease specialist, clinical microbiologist or respiratory specialist, or in accordance with a or guideline that has been endorsed by the Health NZ Hospital.
		and	O Active tuberculosis
			O Documented resistance to one or more first-line medications
			O Suspected resistance to one or more first-line medications (tuberculosis assumed to be contracted in an area with known resistance), as part of regimen containing other second-line agents or
			O Impaired visual acuity (considered to preclude ethambutol use)
			 Significant pre-existing liver disease or hepatotoxicity from tuberculosis medications Significant documented intolerance and/or side effects following a reasonable trial of first-line medications
	or or		ycobacterium avium-intracellulare complex not responding to other therapy or where such therapy is contraindicated atient is under five years of age and has had close contact with a confirmed multi-drug resistant tuberculosis case
	equis	sites (tic Prescrib	eumonia ek boxes where appropriate) ned by, or recommended by an infectious disease specialist or clinical microbiologist, or in accordance with a protocol or guideline that n endorsed by the Health NZ Hospital.
	or		nmunocompromised patient with pneumonia that is unresponsive to first-line treatment
		O Pr	neumococcal pneumonia or other invasive pneumococcal disease highly resistant to other antibiotics
			netrating eye injury sk box where appropriate)
		Prescrib Hospital	bed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and	С	Five day	vs treatment for patients requiring prophylaxis following a penetrating eye injury
			coplasma genitalium sk boxes where appropriate)
	and		as nucleic acid amplification test (NAAT) confirmed Mycoplasma genitalium and is symptomatic
		or	Has tried and failed to clear infection using azithromycin
			D Has laboratory confirmed azithromycin resistance
	and	\sim	eatment is only for 7 days

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	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Tigecycline		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Daptomycin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Lincomycin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Linezolid	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	
Sulphadiazine		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or maternal-foetal medicine specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Teicoplanin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Fosfomycin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Pivmecillinam	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Vancomycin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Aztreonam, Chloramphenicol	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Clindamycin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Fusidic acid	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Colistin sulphomethate [Colestimethate]	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Ketoconazole - Tab 200 mg	

INITIATION

Prerequisites (tick box where appropriate)

()Prescribed by, or recommended by an oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

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:

Amphotericin B - Inj (liposomal) 50 mg vial

INITIATION

and

Prerequisites (tick boxes where appropriate) () Prescribed by, or recommended by a clinical microbiologist, haematologist, infectious disease specialist, oncologist, respiratory specialist or transplant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and Proven or probable invasive fungal infection, to be prescribed under an established protocol or ()

Possible invasive fungal infection

() A multidisciplinary team (including an infectious disease physician or a clinical microbiologist) considers the treatment to be appropriate

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:
Amphotericin B - Inj 50 mg vial	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, haematologist, infectious disease specialist, oncologist, respiratory specialist or transplant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Fluconazole	
)

INITIATION Prerequisites (tick box where appropriate)

()Prescribed by, or recommended by a consultant, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

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:	
Itraconazole		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical immunologist, clinical microbiologist, dermatologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	
Voriconazole		

	ATION – Proven or probable aspergillus infection equisites (tick boxes where appropriate)
(and	O Prescribed by, or recommended by a clinical microbiologist, haematologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	O Patient is immunocompromised
	O Patient has proven or probable invasive aspergillus infection
	ATION – Possible aspergillus infection equisites (tick boxes where appropriate)
(and	O Prescribed by, or recommended by a clinical microbiologist, haematologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	O Patient is immunocompromised
	O Patient has possible invasive aspergillus infection and
	O A multidisciplinary team (including an infectious disease physician) considers the treatment to be appropriate
	ATION – Resistant candidiasis infections and other moulds equisites (tick boxes where appropriate) O Prescribed by, or recommended by a clinical microbiologist, haematologist or infectious disease specialist, or in accordance with a protocol or
and	guideline that has been endorsed by the Health NZ Hospital.

And Patient is immunocompromised

 $m O\,$ Patient has mould strain such as Fusarium spp. and Scedosporium spp

O A multidisciplinary team (including an infectious disease physician or clinical microbiologist) considers the treatment to be appropriate

or

and

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:

Posaconazole

INITIATION Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate)			
O Prescribed by, or recommended by a haematologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
O Patient has acute myeloid leukaemia or O Patient is planned to receive a stem cell transplant and is at high risk for aspergillus infection			
and O Patient is to be treated with high dose remission induction therapy or re-induction therapy			
CONTINUATION Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate)			
O Prescribed by, or recommended by a haematologist or infectious disease specialist, or in accordance with a protocol or guideline that has been			

and	endorsed by the Health NZ Hospital.			
	(and	С	Patient has previously received posaconazole prophylaxis during remission induction therapy	
		or	O Patient is to be treated with high dose remission re-induction therapy	
		or	O Patient is to be treated with high dose consolidation therapy	
			O Patient is receiving a high risk stem cell transplant	

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:
Flucytosine	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Caspofungin	

Prerequisites (tick boxes where appropriate)			
and	С		by, or recommended by a clinical microbiologist, haematologist, infectious disease specialist, oncologist, respiratory specialist or pecialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	O Proven or probable invasive fungal infection, to be prescribed under an established protocol or		
		and	Possible invasive fungal infection
		O	A multidisciplinary team (including an infectious disease physician or a clinical microbiologist) considers the treatment to be appropriate

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:
Clofazimine	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, dermatologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Dapsone	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, dermatologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Cycloserine	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Isoniazid with rifampicin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, dermatologist, paediatrician, public health physician or internal medicine physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Pyrazinamide	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Rifampicin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, dermatologist, internal medicine physician, paediatrician or public health physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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	ł	PATIENT:	
Name:		Name:	
Ward:		NHI:	
Bedaquilin	e		
Re-assessme	multi-drug resistant tuberculosis nt required after 6 months s (tick boxes where appropriate)		
Ο	The person has multi-drug resistant tuberculosis (MDR-TB)		
and	Ministry of Health's Tuberculosis Clinical Network has reviewed the individual case and recommends bedaquiline as part of the treatment regimen		

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:
Isoniazid	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, dermatologist, paediatrician, public health physician or internal medicine physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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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:
Rifabutin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, gastroenterologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Ethambutol hydrochloride	

INITIATION

Prerequisites (tick box where appropriate)

()Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

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:
Para-aminosalicylic Acid	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Protionamide	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Albendazole	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Ivermectin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, dermatologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Artemether with lumefantrine	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Artesunate	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Atovaquone with proguanil hydrochloride	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Chloroquine phosphate	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, dermatologist, infectious disease specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Mefloquine hydrochloride	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, dermatologist, infectious disease specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Pentamidine isethionate	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Primaguine phosphate	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:		
Pyrimethamine			

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or maternal-foetal medicine specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Quinine dihydrochloride	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Sodium stibogluconate	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	
Spiramycin		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a maternal-foetal medicine specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Nitazoxanide	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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	8	PATIENT:
Name:		Name:
Ward:		NHI:
Non-Nucle	oside Reverse Transcriptase Inhibitors	
	• Confirmed HIV s (tick box where appropriate)	
O Pati	ent has confirmed HIV infection	
	• Prevention of maternal transmission s (tick boxes where appropriate)	
or O	Prevention of maternal foetal transmission Treatment of the newborn for up to eight weeks	
Prerequisite	Post-exposure prophylaxis following exposure to HIV s (tick boxes where appropriate) Treatment course to be initiated within 72 hours post exposu	re
and	unknown or detectable viral load greater than 200 copi	
0	r O Patient has had non-consensual intercourse and the cl required	inician considers that the risk assessment indicates prophylaxis is
	\sim	rson from a high HIV prevalence country or risk group whose HIV status
Note: Refer t	o local health pathways or the Australasian Society for HIV, Vira	I Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.ashn
Prerequisite	• Percutaneous exposure s (tick box where appropriate) ent has percutaneous exposure to blood known to be HIV posit	ive

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.

PRESCRIB	ER			PATIENT:
Name:				Name:
Ward:				NHI:
Nucleosi	de F	Reve	rse Transcriptase Inhibitors	
INITIATION Prerequisi			med HIV ox where appropriate)	
Ор	atien	t has	confirmed HIV infection	
			ntion of maternal transmission oxes where appropriate)	
or (ention of maternal foetal transmission ment of the newborn for up to eight weeks	
Prerequisi	ites (tick b	xposure prophylaxis following exposure to HIV oxes where appropriate) ment course to be initiated within 72 hours post exposur	e
and	or	0	Patient has had condomless anal intercourse or reception unknown or detectable viral load greater than 200 copie	ve vaginal intercourse with a known HIV positive person with an is per ml
	or	0 0		a known HIV positive person nician considers that the risk assessment indicates prophylaxis is
	or	0	required Patient has had condomless anal intercourse with a per is unknown	son from a high HIV prevalence country or risk group whose HIV status
Note: Refe	er to l	ocal	nealth pathways or the Australasian Society for HIV, Viral	Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.ashn
Prerequisi	tes (tick b	aneous exposure ox where appropriate) percutaneous exposure to blood known to be HIV positi	ve

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.

PRESCRIBEF		PATIENT:
Name:		Name:
Ward:		NHI:
Protease In	hibitors	
_	Confirmed HIV (tick box where appropriate)	
O Pati	ent has confirmed HIV infection	
_	Prevention of maternal transmission (tick boxes where appropriate)	
or O	Prevention of maternal foetal transmission Treatment of the newborn for up to eight weeks	
Prerequisite	Post-exposure prophylaxis following exposure to HIV s (tick boxes where appropriate) Treatment course to be initiated within 72 hours post exposure	re
and	unknown or detectable viral load greater than 200 copie	
0	r O Patient has had non-consensual intercourse and the cli required	nician considers that the risk assessment indicates prophylaxis is
	$\hat{}$	rson from a high HIV prevalence country or risk group whose HIV status
Note: Refer to	o local health pathways or the Australasian Society for HIV, Vira	Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.ashn
Prerequisite	Percutaneous exposure s (tick box where appropriate) ent has percutaneous exposure to blood known to be HIV positi	ve

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.

PRESCRIE	BER			PATIENT:
Name:				Name:
Ward:				NHI:
Strand T	rans	sfer	Inhibitors	
INITIATIO Prerequis			med HIV ox where appropriate)	
0	Patie	nt has	confirmed HIV infection	
			ntion of maternal transmission oxes where appropriate)	
or	0 0		ention of maternal foetal transmission ment of the newborn for up to eight weeks	
		(tick b	exposure prophylaxis following exposure to HIV exposes where appropriate) ment course to be initiated within 72 hours post exposure	e
and	or	0	Patient has had condomless anal intercourse or recepti unknown or detectable viral load greater than 200 copie	ve vaginal intercourse with a known HIV positive person with an es per ml
		Ο	Patient has shared intravenous injecting equipment with	n a known HIV positive person
	or	0	Patient has had non-consensual intercourse and the clin required	nician considers that the risk assessment indicates prophylaxis is
		0	Patient has had condomless anal intercourse with a per is unknown	son from a high HIV prevalence country or risk group whose HIV status
Note: Ref	er to	local	nealth pathways or the Australasian Society for HIV, Vira	Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.ash
Prerequis	sites	(tick k	taneous exposure nox where appropriate) percutaneous exposure to blood known to be HIV positi	ve

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:

Ledipasvir with sofosbuvir

Note: Only for use in patients with approval by the Hepatitis C Treatment Panel (HepCTP). Applications will be considered by HepCTP at its regular meetings and approved subject to eligibility according to the Access Criteria (set out in Section B of the Pharmaceutical Schedule).

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:
Cidofovir	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist, otolaryngologist or oral surgeon, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Foscarnet sodium	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Ganciclovir	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

			determine if a patient meets the restrictions for funding in the hos nunity funding, see the Special Authority Criteria.	pital setting. For more details, refer to Section H of the Pharmaceutical
PRES	CRIB	ER	PAT	ENT:
Name:			Nar	e:
Ward:			NHI:	
Valga	inci	clovir		
Re-as	sess quis	ment requ ites (tick	asplant cytomegalovirus prophylaxis quired after 3 months (box where appropriate) as undergone a solid organ transplant and requires valganciclovi	r for CMV prophylaxis
Re-as	sess	ment req	• Transplant cytomegalovirus prophylaxis quired after 3 months < boxes where appropriate)	
	or	and	 Patient has undergone a solid organ transplant and received a CMV prophylaxis Patient is to receive a maximum of 90 days of valganciclovir p Patient has received pulse methylprednisolone for acute rejective 	rophylaxis following anti-thymocyte globulin
			prophylaxis Patient is to receive a maximum of 90 days of valganciclovir p g transplant cytomegalovirus prophylaxis	
	quis) F	ites (tick	quired after 12 months x boxes where appropriate) ed by, or recommended by a relevant specialist, or in accordance	with a protocol or guideline that has been endorsed by the Health NZ
	(and	D Patie	tient has undergone a lung transplant The donor was cytomegalovirus positive and the patient is cyt	
	and	or O	The recipient is cytomegalovirus positive	
		N – Cytor	tient has a high risk of CMV disease megalovirus in immunocompromised patients k boxes where appropriate)	
ſ	(and) Patie	tient is immunocompromised	
		0	Patient has cytomegalovirus syndrome or tissue invasive dise	ase
		or O	Patient has rapidly rising plasma CMV DNA in absence of dis	ease
		or O	Patient has cytomegalovirus retinitis	

Form RS1902	HOSPITAL MEDICINES LIST Page 208
July 2024	RESTRICTIONS CHECKLIST
Use this checklist to determine if a patient meets the re Schedule. For community funding, see the Special Au	estrictions for funding in the hospital setting . For more details, refer to Section H of the Pharmaceutical uthority Criteria.
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Emtricitabine with tenofovir disoproxil	
INITIATION – Confirmed HIV Prerequisites (tick box where appropriate)	
O Patient has confirmed HIV infection	
INITIATION – Prevention of maternal transmissio Prerequisites (tick boxes where appropriate)	n
O Prevention of maternal foetal transm	ission
O Treatment of the newborn for up to e	ight weeks
INITIATION – Post-exposure prophylaxis followin Prerequisites (tick boxes where appropriate)	g non-occupational exposure to HIV
O Treatment course to be initiated with	in 72 hours post exposure
O Patient has had unprotected re	eceptive anal intercourse with a known HIV positive person
O Patient has shared intravenous	s injecting equipment with a known HIV positive person
	al intercourse and the clinician considers that the risk assessment indicates prophylaxis is
INITIATION – Percutaneous exposure	
Prerequisites (tick box where appropriate)	
O Patient has percutaneous exposure to bloc	d known to be HIV positive
INITIATION – Pre-exposure prophylaxis Re-assessment required after 24 months Prerequisites (tick boxes where appropriate)	
O Patient has tested HIV negative, doe	es not have signs or symptoms of acute HIV infection and has been assessed for HIV seroconversion
O The Practitioner considers the patier	nt is at elevated risk of HIV exposure and use of PrEP is clinically appropriate
Note: Refer to local health pathways or the Australa	sian Society for HIV, Viral Hepatitis and Sexual Health Medicine clinical guidelines (https://ashm.org.au/HIV/
CONTINUATION – Pre-exposure prophylaxis Re-assessment required after 24 months Prerequisites (tick boxes where appropriate)	
	es not have signs or symptoms of acute HIV infection and has been assessed for HIV seroconversion
The Practitioner considers the patier	nt is at elevated risk of HIV exposure and use of PrEP is clinically appropriate

Note: Refer to local health pathways or the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine clinical guidelines (https://ashm.org.au/HIV/P

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.

PRES	CR	IBER	PATIENT:
Name	:		Name:
Ward:			NHI:
Osel	tan	nivir	
INITI. Prere		ON isites (tick boxes where appropriate)	
	O Only for hospitalised patient with known or suspected influenza		a
or O For prophylaxis of influenza in hospitalised patients as part of a Health NZ Hospital approved infections control plan			a Health NZ Hospital approved infections control plan

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.

PRES	SCR	IBER	PATIENT:
Name	e:		Name:
Ward	:		NHI:
Zana	mi	vir - Powder for inhalation 5 mg	
INITI Prer		ON isites (tick boxes where appropriate)	
		O Only for hospitalised patient with known or suspected influenza	a
O For prophylaxis of influenza in hospitalised patients as part of a Health NZ Hospital approved infections control plan			a Health NZ Hospital approved infections control plan

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:
COVID-19 treatments	

INITIATION

Prerequisites (tick box where appropriate)

Only if patient meets access criteria (as per https://pharmac.govt.nz/covid-oral-antivirals). Note the supply of treatment is via Pharmac's approved distribution process. Refer to the Pharmac website for more information about this and stock availability ()

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:
COVID-19 treatments	

INITIATION

Prerequisites (tick box where appropriate)

Only if patient meets access criteria (as per https://pharmac.govt.nz/covid-oral-antivirals). Note the supply of treatment is via Pharmac's approved distribution process. Refer to the Pharmac website for more information about this and stock availability ()

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:
Remdesivir	

INITIATION – Treatment of mild to moderate COVID-19 Prerequisites (tick box where appropriate)

 \bigcirc Only if patient meets access criteria (as per https://pharmac.govt.nz/covid-oral-antivirals). Note the supply of treatment is via Pharmac's approved distribution process. Refer to the Pharmac website for more information about this and stock availability

Re-assessmer	COVID-19 in hospitalised patients ent required after 5 doses s (tick boxes where appropriate)
and and and and and and and	Patient is hospitalised with confirmed (or probable) symptomatic COVID-19 Patient is considered to be at high risk of progression to severe disease Patient's symptoms started within the last 7 days Patient does not require, or is not expected to require, mechanical ventilation Not to be used in conjunction with other funded COVID-19 antiviral treatments Treatment not to exceed five days

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:
Interferon gamma	
INITIATION Prerequisites (tick box where appropriate)	
${\rm O}~$ Patient has chronic granulomatous disease and requires interferon g	gamma

RS1827 - Pegylated interferon alfa-2a

Chronic Hepatitis C - genotype 1 infection treatment more than 4 years prior - INITIATION Chronic hepatitis C - genotype 1 infection - CONTINUATION Chronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV or genotype 2 or 3 post liv - INITIATION	216 er transplant
Chronic hepatitis C - genotype 2 or 3 infection without co-infection with HIV - INITIATION Hepatitis B - INITIATION Myeloproliferative disorder or cutaneous T cell lymphoma - INITIATION Myeloproliferative disorder or cutaneous T cell lymphoma - CONTINUATION Ocular surface squamous neoplasia - INITIATION	217 217 217 217 218
Ocular surface squamous neoplasia - INTIATION Ocular surface squamous neoplasia - CONTINUATION Post-allogenic bone marrow transplant - INITIATION Post-allogenic bone marrow transplant - CONTINUATION	218 218

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:

Pegylated interferon alfa-2a

INITIATION – Chronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV or genotype 2 or 3 post liver transplant Re-assessment required after 48 weeks	
Prerequisites (tick boxes where appropriate)	
O Patient has chronic hepatitis C, genotype 1, 4, 5 or 6 infection or O Patient has chronic hepatitis C and is co-infected with HIV or	
O Patient has chronic hepatitis C genotype 2 or 3 and has received a liver transplant	
Note: Consider stopping treatment if there is absence of a virological response (defined as at least a 2-log reduction in viral load) following 12 weeks of treatment since this is predictive of treatment failure. Consider reducing treatment to 24 weeks if serum HCV RNA level at Week 4 is undetectable by sensitive PCR assay (less than 50IU/ml) AND Baseline serum HCV RNA is less than 400,000IU/ml.	
CONTINUATION – Chronic hepatitis C - genotype 1 infection Re-assessment required after 48 weeks Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a gastroenterologist, infectious disease specialist or general physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	
O Patient has chronic hepatitis C, genotype 1 and	
O Patient has had previous treatment with pegylated interferon and ribavirin and	
O Patient has responder relapsed	
or O Patient was a partial responder	
Patient is to be treated in combination with boceprevir	
INITIATION – Chronic Hepatitis C - genotype 1 infection treatment more than 4 years prior Re-assessment required after 48 weeks Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a gastroenterologist, infectious disease specialist or general physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	
O Patient has chronic hepatitis C, genotype 1 and	
O Patient has had previous treatment with pegylated interferon and ribavirin and	
O Patient has responder relapsed	
or O Patient was a partial responder	
O Patient received interferon treatment prior to 2004	
And O Patient is to be treated in combination with boceprevir	

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 th	e Pharmaceutical
Schedule. For community funding, see the Special Authority Criteria.			

PRESCRIBER	PATIENT:	
Name: Name:		
Nard: NHI:		
Pegylated interferon alfa-2a - continued		
INITIATION – Chronic hepatitis C - genotype 2 or 3 infection without Re-assessment required after 6 months Prerequisites (tick box where appropriate) O Patient has chronic hepatitis C, genotype 2 or 3 infection	It co-infection with HIV	
INITIATION – Hepatitis B Re-assessment required after 48 weeks Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a gastroenterologist, infect guideline that has been endorsed by the Health NZ Hospital. and	tious disease specialist or general physician, or in accordance with a protocol or	
Patient has confirmed Hepatitis B infection (HBsAg position) and Patient is Hepatitis B treatment-naive and ALT > 2 times Upper Limit of Normal and HBV DNA < 10 log10 IU/ml and O HBeAg positive or	tive for more than 6 months) nits/ml and significant fibrosis (greater than or equal to Metavir Stage F2 or	
and Compensated liver disease and No continuing alcohol abuse or intravenous drug use and Not co-infected with HCV, HIV or HDV and Neither ALT nor AST > 10 times upper limit of normal and No history of hypersensitivity or contraindications to peg	yylated interferon	
INITIATION – myeloproliferative disorder or cutaneous T cell lymph Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Patient has a cutaneous T cell lymphoma* or O Patient has a myeloproliferative disorder*	noma	
or Patient is intolerant of hydroxyurea Treatment with anagrelide and busulfan is not clini or Patient has a myeloproliferative disorder and Patient is pregnant, planning pregnancy or lactation		

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:	
Pegylated interferon alfa-2a - continued		
CONTINUATION – myeloproliferative disorder or cutaneous T cell lymph Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	noma	
No evidence of disease progression and The treatment remains appropriate and patient is benefitting f and O Patient has a cutaneous T cell lymphoma* O Patient has a myeloproliferative disorder*	from treatment	
and	tment with anagrelide and busulfan remains clinically inappropriate	
INITIATION – ocular surface squamous neoplasia Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Patient has ocular surface squamous neoplasia*		
CONTINUATION – ocular surface squamous neoplasia Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by an ophthalmologist, or in accord Hospital. and O The treatment remains appropriate and patient is benefitting from tr Note: Indications marked with * are unapproved indications	dance with a protocol or guideline that has been endorsed by the Health NZ eatment	
INITIATION – post-allogenic bone marrow transplant Re-assessment required after 3 months Prerequisites (tick box where appropriate) O Patient has received an allogeneic bone marrow transplant* and has evidence of disease relapse		
CONTINUATION – post-allogenic bone marrow transplant Re-assessment required after 3 months Prerequisites (tick box where appropriate) O Patient is responding and ongoing treatment remains appropriate Note: Indications marked with * are unapproved indications		

Signed: Date:

Musculoskeletal System

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:
Edrophonium chloride	
INITIATION Prerequisites (tick box where appropriate)	
${ m O}~$ For the diagnosis of myasthenia gravis	

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.

PRES	SCRI	BER		PATIENT:
Name	э:			Name:
Ward	:			NHI:
Hyd	roxy	ychlo	oroquine	
INIT Prer			(tick boxes where appropriate) Rheumatoid arthritis	
	or or	0 0 0	Systemic or discoid lupus erythematosus Malaria treatment or suppression Relevant dermatological conditions (cutaneous forms of lupus a	and lichen planus, cutaneous vasculitides and mucosal ulceration)
	or	Ο	Sarcoidosis (pulmonary and non-pulmonary)	

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:
Denseumah	

Denosumab

NITIATION Prerequisites (tick boxes where appropriate)			
and	0	The	patient has severe, established osteoporosis
		Ο	The patient is female and postmenopausal
	or	Ο	The patient is male or non-binary
and	I		
		0	History of one significant osteoporotic fracture demonstrated radiologically and documented bone mineral density (BMD) greater than or equal to 2.5 standard deviations below the mean normal value in young adults (i.e. T-Score less than or equal to -2.5) (see Note)
	or	Ο	History of one significant osteoporotic fracture demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of major logistical, technical or pathophysiological reasons
	or	Ο	History of two significant osteoporotic fractures demonstrated radiologically
	or	Ο	Documented T-Score less than or equal to -3.0 (see Note)
		Ο	A 10-year risk of hip fracture greater than or equal to 3%, calculated using a published risk assessment algorithm (e.g. FRAX or Garvan) which incorporates BMD measurements (see Note)
	or	0	Patient has had a Special Authority approval for alendronate (Underlying cause - Osteoporosis) prior to 1 February 2019 or has had a Special Authority approval for raloxifene
and	Ο	Zole	dronic acid is contraindicated because the patient's creatinine clearance is less than 35 mL/min
and	0		patient has experienced at least one symptomatic new fracture after at least 12 months' continuous therapy with a funded esorptive agent at adequate doses (see Notes)
and	0	The	patient must not receive concomitant treatment with any other funded antiresorptive agent for this condition or teriparatide

Note:

- a) BMD (including BMD used to derive T-Score) must be measured using dual-energy x-ray absorptiometry (DXA). Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable.
- b) Evidence suggests that patients aged 75 years and over who have a history of significant osteoporotic fracture demonstrated radiologically are very likely to have a T-Score less than or equal to -2.5 and, therefore, do not require BMD measurement for treatment with denosumab.
- c) Osteoporotic fractures are the incident events for severe (established) osteoporosis and can be defined using the WHO definitions of osteoporosis and fragility fracture. The WHO defines severe (established) osteoporosis as a T-score below -2.5 with one or more associated fragility fractures. Fragility fractures are fractures that occur as a result of mechanical forces that would not ordinarily cause fracture (minimal trauma). The WHO has quantified this as forces equivalent to a fall from a standing height or less.
- d) A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.
- e) Antiresorptive agents and their adequate doses for the purposes of this Special Authority are defined as: risedronate sodium tab 35 mg once weekly; alendronate sodium tab 70 mg or tab 70 mg with cholecalciferol 5,600 iu once weekly; raloxifene hydrochloride tab 60 mg once daily. If an intolerance of a severity necessitating permanent treatment withdrawal develops during the use of one antiresorptive agent, an alternate antiresorptive agent must be trialled so that the patient achieves the minimum requirement of 12 months' continuous therapy.

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	PATIENT:		
Name:	Name:		
Ward:	NHI:		

Raloxifene

		(tick boxes where appropriate)
or	0	History of one significant osteoporotic fracture demonstrated radiologically and documented bone mineral density (BMD) greater than or equal to 2.5 standard deviations below the mean normal value in young adults (i.e. T-Score less than or equal to -2.5) (see Notes)
	0	History of one significant osteoporotic fracture demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of major logistical, technical or pathophysiological reasons. It is unlikely that this provision would apply to many patients under 75 years of age
or	Ο	History of two significant osteoporotic fractures demonstrated radiologically
or	Ο	Documented T-Score greater than or equal to -3.0 (see Notes)
or	Ο	A 10-year risk of hip fracture greater than or equal to 3%, calculated using a published risk assessment algorithm (e.g. FRAX or Garvan) which incorporates BMD measurements (see Notes)
or	Ο	Patient has had a Special Authority approval for zoledronic acid (Underlying cause - Osteoporosis) or has had a Special Authority approval for alendronate (Underlying cause - Osteoporosis) prior to 1 February 2019

Note:

- a) BMD (including BMD used to derive T-Score) must be measured using dual-energy x-ray absorptiometry (DXA). Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable.
- b) Evidence suggests that patients aged 75 years and over who have a history of significant osteoporotic fracture demonstrated radiologically are very likely to have a T-Score less than or equal to -2.5 and, therefore, do not require BMD measurement for raloxifene funding.
- c) Osteoporotic fractures are the incident events for severe (established) osteoporosis, and can be defined using the WHO definitions of osteoporosis and fragility fracture. The WHO defines severe (established) osteoporosis as a T-score below -2.5 with one or more associated fragility fractures. Fragility fractures are fractures that occur as a result of mechanical forces that would not ordinarily cause fracture (minimal trauma). The WHO has quantified this as forces equivalent to a fall from a standing height or less.
- d) A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

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	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Teriparatide		

	essmen	t required after 18 months (tick boxes where appropriate)
	O nd	The patient has severe, established osteoporosis
		The patient has a documented T-score less than or equal to -3.0 (see Notes)
	Ο	The patient has had two or more fractures due to minimal trauma
a		The patient has experienced at least one symptomatic new fracture after at least 12 months' continuous therapy with a funded antiresorptive agent at adequate doses (see Notes)

Note:

a) The bone mineral density (BMD) measurement used to derive the T-score must be made using dual-energy x-ray absorptiometry (DXA). Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable

- b) Antiresorptive agents and their adequate doses for the purposes of this restriction are defined as: alendronate sodium tab 70 mg or tab 70 mg with colecalciferol 5,600 iu once weekly; raloxifene hydrochloride tab 60 mg once daily; zoledronic acid 5 mg per year. If an intolerance of a severity necessitating permanent treatment withdrawal develops during the use of one antiresorptive agent, an alternate antiresorptive agent must be trialled so that the patient achieves the minimum requirement of 12 months' continuous therapy.
- A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral C) body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

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:
Rasburicase	

INITIATION

Prerequisites (tick box where appropriate)

()Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

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:

Febuxostat

(С	Patie	ent has been diagnosed with gout
and			
		0	The patient has a serum urate level greater than 0.36 mmol/l despite treatment with allopurinol at doses of at least 600 mg/day and addition of probenecid at doses of up to 2 g per day or maximum tolerated dose
	or	Ο	The patient has experienced intolerable side effects from allopurinol such that treatment discontinuation is required and serum urate remains greater than 0.36 mmol/l despite use of probenecid at doses of up to 2 g per day or maximum tolerated dose
	or	0	The patient has renal impairment such that probenecid is contraindicated or likely to be ineffective and serum urate remains
	or	~	greater than 0.36 mmol/l despite optimal treatment with allopurinol (see Note)
		\bigcirc	The patient has previously had an initial Special Authority approval for benzbromarone for treatment of gout.

INITIATION – Tumour lysis syndrome Re-assessment required after 6 weeks

Prerequisites (tick boxes where appropriate)

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

O Patient is scheduled to receive cancer therapy carrying an intermediate or high risk of tumour lysis syndrome and

O Patient has a documented history of allopurinol intolerance

CONTINUATION – Tumour lysis syndrome

Re-assessment required after 6 weeks **Prerequisites** (tick box where appropriate)

()

and

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

The treatment remains appropriate and patient is benefitting from treatment

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:
Ward:	NHI:

Sugammadex

INITI Prere			(tick boxes where appropriate)
	or	0	Patient requires reversal of profound neuromuscular blockade following rapid sequence induction that has been undertaken using rocuronium (i.e. suxamethonium is contraindicated or undesirable)
	or	Ο	Severe neuromuscular degenerative disease where the use of neuromuscular blockade is required
		Ο	Patient has an unexpectedly difficult airway that cannot be intubated and requires a rapid reversal of anaesthesia and neuromuscular blockade
	or or	Ο	The duration of the patient's surgery is unexpectedly short
		Ο	Neostigmine or a neostigmine/anticholinergic combination is contraindicated (for example the patient has ischaemic heart disease, morbid obesity or COPD)
	or	0	Patient has a partial residual block after conventional reversal

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:
Etoricoxib	
INITIATION Prerequisites (tick box where appropriate)	
O For in-vivo investigation of allergy only	

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:
Capsaicin	

Prerequisites (tick box where appropriate)

O Patient has osteoarthritis that is not responsive to paracetamol and oral non-steroidal anti-inflammatories are contraindicated

Nervous System

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:
Riluzole	
and by the Health NZ Hospital. and O The patient has amyotrophic lateral sclerosis with disease dur and O The patient has at least 60 percent of predicted forced vital ca and O The patient has not undergone a tracheostomy and O The patient has not experienced respiratory failure and O The patient has not experienced respiratory failure	
O The patient is ambulatory	

O The patient is able to use upper limbs or

 \bigcirc The patient is able to swallow

CONTINUATION

or

Re-assessment required after 18 months

Prerequisites (tick boxes where appropriate)

(and	С	The p	patient has not undergone a tracheostomy
and (С	The p	patient has not experienced respiratory failure
		Ο	The patient is ambulatory
	or	Ο	The patient is able to use upper limbs
	or	Ο	The patient is able to swallow

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	PATIENT:
Name:	Name:
Ward:	NHI:
Sucrose	
INITIATION Prerequisites (tick box where appropriate)	
${\mathsf O}$ For use in neonatal patients only	

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.

PRES	CRIBER		PATIENT:				
Name	:		Name:				
Ward:			NHI:				
Meth	oxyflur	ane					
	ATION equisites	(tick boxes where appropriate)					
	and	O Patient is undergoing a painful procedure with an expected duration of less than one hour					
	0	Only to be used under supervision by a medical practitioner or	r nurse who is trained in the use of methoxyflurane				

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:
Paracetamol	

INITIATION

Prerequisites (tick box where appropriate)

()Intravenous paracetamol is only to be used where other routes are unavailable or impractical, or where there is reduced absorption. The need for IV paracetamol must be re-assessed every 24 hours

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:
Capsaicin	
INITIATION Prerequisites (tick box where appropriate)	
${ m O}~$ For post-herpetic neuralgia or diabetic peripheral neuropathy	

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:

Vigabatrin

	TIATIO assess		required after 15 months		
Pre	requis	ites	ick boxes where appropriate)		
		O Patient has infantile spasms			
Patient has epilepsy					
			O Seizures are not adequately controlled with optimal treatment with other antiepilepsy agents or		
Seizures are controlled adequately but the patient has experienced unacceptable side effects from optimal treatment with other antiepilepsy agents					
		or	O Patient has tuberous sclerosis complex		
	and	\subseteq			
			O Patient is, or will be, receiving regular automated visual field testing (ideally before starting therapy and on a 6-monthly basis thereafter)		
		or O It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields			
\subseteq					
	NTINU. requis		I ick boxes where appropriate)		
	and	O The patient has demonstrated a significant and sustained improvement in seizure rate or severity and or quality of life			
		or	O Patient is receiving regular automated visual field testing (ideally every 6 months) on an ongoing basis for duration of treatment with vigabatrin		

O It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields

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:
Lacosamide	
INITIATION Re-assessment required after 15 months Prerequisites (tick boxes where appropriate)	
O Patient has focal epilepsy and O Seizures are not adequately controlled by, or patient has exper	ienced unacceptable side effects from, optimal treatment with all of the
following: sodium valproate, topiramate, levetiracetam, and an Note: Those of childbearing potential are not required to trial phenytoin sodium required to trial sodium valproate.	y two of carbamazepine, lamotrigine, and phenytoin sodium (see Note) n, sodium valproate, or topiramate. Those who can father children are not

CONTINUATION

Prerequisites (tick box where appropriate)

() Patient has demonstrated a significant and sustained improvement in seizure rate or severity and/or quality of life compared with that prior to starting lacosamide treatment

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:
Stivingental	

Stiripentol

and

()

INITIATION
Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)
O Prescribed by, or recommended by a paediatric neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
O Patient has confirmed diagnosis of Dravet syndrome
and O Seizures have been inadequately controlled by appropriate courses of sodium valproate, clobazam and at least two of the following: topiramate, levetiracetam, ketogenic diet
Note: Those of childbearing potential are not required to trial sodium valproate or topiramate. Those who can father children are not required to trial sodium valproate.
CONTINUATION
Prerequisites (tick box where appropriate)

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

Patient continues to benefit from treatment as measured by reduced seizure frequency from baseline

Prerequisites (tick boxes where appropriate)

not tolerated or are contraindicated

()

or

or

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	PATIENT:
Name:	Name:
Ward:	NHI:
Hyoscine hydrobromide - Patch 1.5 mg	

Control of intractable nausea, vomiting, or inability to swallow saliva in the treatment of malignancy or chronic disease where the

For treatment of post-operative nausea and vomiting where cyclizine, droperidol and a 5HT3 antagonist have proven ineffective, are

Control of clozapine-induced hypersalivation where trials of at least two other alternative treatments have proven ineffective

patient cannot tolerate or does not adequately respond to oral anti-nausea agents

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:
Aprepitant	

Prerequisites (tick box where appropriate)

O Patient is undergoing highly emetogenic chemotherapy and/or anthracycline-based chemotherapy for the treatment of malignancy

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:	
Della subleme		

Paliperidone

	ssess	smen		uired after 12 months boxes where appropriate)
	or	0	The	patient has had an initial Special Authority approval for risperidone depot injection or olanzapine depot injection
		an	O	The patient has schizophrenia or other psychotic disorder
The patient has tried but failed to comply with treatment using oral atypical antipsychotic agents and			The patient has tried but failed to comply with treatment using oral atypical antipsychotic agents	
		an	Ö	The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in the last 12 months

CONTINUATION

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

> ()The initiation of paliperidone depot injection has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of an atypical antipsychotic depot injection

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:
Paliperidone palmitate	
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O The patient has schizophrenia and O The patient has had an initial Special Authority approval for patient	liperidone once-monthly depot injection
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate)	
O The initiation of paliperidone depot injection has been associated wi corresponding period of time prior to the initiation of an atypical antip	

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:
Olanzapine	

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

 \bigcirc The initiation of olanzapine depot injection has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of an atypical antipsychotic depot injection

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:

Risperidone

Re-a	INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)				
	or	0	0	patient has had an initial Special Authority approval for paliperidone depot injection or olanzapine depot injection The patient has schizophrenia or other psychotic disorder	
		and	Ο	The patient has tried but failed to comply with treatment using oral atypical antipsychotic agents The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in the last 12 months	

CONTINUATION

Re-assessment required after 12 months **Prerequisites** (tick box where appropriate)

O The initiation of risperidone depot injection has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of an atypical antipsychotic depot injection

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:

Aripiprazole

IN	ITI	АΤ	10	N
		~'		

	Re-assessment required after 12 months					
Prerequisites (tick boxes where appropriate)						
		0	Patient has a current Special Authority approval for olanzapine depot injection, risperidone depot injection or paliperidone depot injection			
	an	d O	Patient has tried but has experienced an inadequate response to, or intolerable side effects from, prior therapy with olanzapine depot injection, risperidone depot injection or paliperidone depot injection			
10	0	have	nt has been unable to access olanzapine depot injection due to supply issues with olanzapine depot injection, or otherwise would been initiated on olanzapine depot injection but has been unable to due to supply issues with olanzapine depot injection. (see below for the olanzapine Special Authority criteria for new olanzapine depot injection patients prior to 1 April 2024)			
Note: T	he Ola	nzapin	e depot injection Special Authority criteria that apply to criterion 2 in this Aripiprazole Special Authority application are as follows:			
• The	patient	has h	ad an initial Special Authority approval for paliperidone depot injection or risperidone depot injection; or			
All of	f the fo	llowing	r.			
• T	he pat	ient ha	s schizophrenia; and			
• T	The patient has tried but failed to comply with treatment using oral atypical antipsychotic agents; and					
	• The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in the last 12 months.					

CONTINUATION

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

O The initiation of aripiprazole depot injection has been associated with fewer days of intensive intervention than prior to the initiation of an atypical antipsychotic depot injection

SCRIB	ER		PATIENT:
ə:			Name:
:			NHI:
iple	Scler	osis	
teriflu assess	nomic ment r	le equired	clerosis - dimethyl fumarate, fingolimod, glatiramer acetate, interferon beta-1-alpha, interferon beta-1-beta, natalizun after 12 months s where appropriate)
	Prescril IZ Hos		or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the He
	(and	neu	ignosis of multiple sclerosis (MS) meets the McDonald 2017 diagnostic criteria for MS and has been confirmed by a urologist
	and		ient has an EDSS score between 0 – 6.0
	and	Pat	tient has had at least one significant attack of MS in the previous 12 months or two significant attacks in the past 24 months
		and and	 Each significant attack must be confirmed by the applying neurologist or general physician (the patient may not necessarily have been seen by them during the attack, but the neurologist/physician must be satisfied that the clinical features were characteristic) Each significant attack is associated with characteristic new symptom(s)/sign(s) or substantially worsening of previously experienced symptoms(s)/sign(s) Each significant attack has lasted at least one week and has started at least one month after the onset of a previous
		and C	attack (where relevant) Each significant attack can be distinguished from the effects of general fatigue; and is not associated with a fever (T> 37.5°C)
		c	 C Each significant attack is severe enough to change either the EDSS or at least one of the Kurtze Functional System scores by at least 1 point C Each significant attack is a recurrent paroxysmal symptom of multiple sclerosis (tonic seizures/spasms, trigeminal neuralgia, Lhermitte's symptom)
	and (and	D Evi	dence of new inflammatory activity on an MRI scan within the past 24 months
		or or or	 A sign of that new inflammatory activity on MRI scanning (in criterion 5 immediately above) is a gadolinium enhancing lesion A sign of that new inflammatory activity is a lesion showing diffusion restriction A sign of that new inflammatory is a T2 lesion with associated local swelling
		or or	A sign of that new inflammatory activity is a prominent T2 lesion that clearly is responsible for the clinical features of a recent attack that occurred within the last 2 years
		C	A sign of that new inflammatory activity is new T2 lesions compared with a previous MRI scan

Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.

 \bigcirc

and

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	PATIENT:		
Name:	Name:		
Ward:	NHI:		

Multiple Sclerosis - continued

CONTINUATION - Multiple Sclerosis - dimethyl fumarate, fingolimod, glatiramer acetate, interferon beta-1-alpha, interferon beta-1-beta, natalizumab and teriflunomide

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

Patient has had an EDSS score of 0 to 6.0 (inclusive) with or without the use unilateral or bilateral aids at any time in the last six months (ie the patient has walked 100 metres or more with or without aids in the last six months) Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.

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.

SCRIBER	PATIENT:
ə:	Name:
:	NHI:
iple Sclerosis	
assessment required a requisites (tick boxes	
and Patie	nosis of multiple sclerosis (MS) meets the McDonald 2017 diagnostic criteria for MS and has been confirmed by a ologist ent has an EDSS score between 0 – 6.0 ent has had at least one significant attack of MS in the previous 12 months or two significant attacks in the past 24 months
and and and and and and and or	Each significant attack must be confirmed by the applying neurologist or general physician (the patient may not necessarily have been seen by them during the attack, but the neurologist/physician must be satisfied that the clinical features were characteristic) Each significant attack is associated with characteristic new symptom(s)/sign(s) or substantially worsening of previously experienced symptoms(s)/sign(s) Each significant attack has lasted at least one week and has started at least one month after the onset of a previous attack (where relevant) Each significant attack can be distinguished from the effects of general fatigue; and is not associated with a fever (T> 37.5°C) O Each significant attack is severe enough to change either the EDSS or at least one of the Kurtze Functional System scores by at least 1 point
and	O Each significant attack is a recurrent paroxysmal symptom of multiple sclerosis (tonic seizures/spasms, trigeminal neuralgia, Lhermitte's symptom) ence of new inflammatory activity on an MRI scan within the past 24 months A sign of that new inflammatory activity on MRI scanning (in criterion 5 immediately above) is a gadolinium enhancing lesion
or or or or	 A sign of that new inflammatory activity is a lesion showing diffusion restriction A sign of that new inflammatory is a T2 lesion with associated local swelling A sign of that new inflammatory activity is a prominent T2 lesion that clearly is responsible for the clinical features of a recent attack that occurred within the last 2 years A sign of that new inflammatory activity is new T2 lesions compared with a previous MRI scan

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:
Multiple Sclerosis - continued	
NZ Hospital.	cordance with a protocol or guideline that has been endorsed by the Health t the use unilateral or bilateral aids at any time in the last six months (ie
Note: Treatment on two or more funded multiple sclerosis treatments simultant INITIATION – Primary Progressive Multiple Sclerosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in activity and NZ Hospital.	cordance with a protocol or guideline that has been endorsed by the Health
 Diagnosis of primary progressive multiple sclerosis (PPMS) moneurologist and Patient has an EDSS 2.0 (score equal to or greater than 2 on grand Patient has no history of relapsing remitting multiple sclerosis 	eets the 2017 McDonald criteria and has been confirmed by a byramidal functions) to EDSS 6.5
NZ Hospital.	cordance with a protocol or guideline that has been endorsed by the Health me in the last six months (ie patient has walked 20 metres with bilateral

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:
Melatonin	
limited to, autism spectrum disorder or attention deficit hypera and Behavioural and environmental approaches have been tried o and Funded modified-release melatonin is to be given at doses no and Patient is aged 18 years or under CONTINUATION – insomnia secondary to neurodevelopmental disorder Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	somnia secondary to a neurodevelopmental disorder (including, but not ctivity disorder) r are inappropriate greater than 10 mg per day
 Prescribed by, or recommended by a psychiatrist, paediatrician, neu guideline that has been endorsed by the Health NZ Hospital. and 	rologist or respiratory specialist, or in accordance with a protocol or
Patient is aged 18 years or under and Patient has demonstrated clinically meaningful benefit from fur and	iscontinuation within the past 12 months and has had a recurrence of
INITIATION – insomnia where benzodiazepines and zopicione are contra Prerequisites (tick boxes where appropriate)	indicated
Patient has insomnia and benzodiazepines and zopiclone are and For in-hospital use only	contraindicated

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:

Nusinersen

ITIATION e-assessmer	It required after 12 months
erequisites	(tick boxes where appropriate)
O	Patient has genetic documentation of homozygous SMN1 gene deletion, homozygous SMN1 point mutation, or compound heterozygous mutation
O	Patient is 18 years of age or under
and	O Patient has experienced the defined signs and symptoms of SMA type I, II or IIIa prior to three years of age
	O Patient is pre-symptomatic
	and O Patient has three or less copies of SMN2
ONTINUATIO	DN It required after 12 months
	(tick boxes where appropriate)
and	There has been demonstrated maintenance of motor milestone function since treatment initiation
O	Patient does not require invasive permanent ventilation (at least 16 hours per day), in the absence of a potentially reversible cause while being treated with nusinersen
and	Nusinersen not to be administered in combination other SMA disease modifying treatments or gene therapy

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:

Risdiplam

INITIATION Re-assessment required after 12 months		
	es (tick boxes where appropriate)	
and	Patient has genetic documentation of homozygous SMN1 gene deletion, homozygous SMN1 point mutation, or compound heterozygous mutation	
and	D Patient is 18 years of age or under	
	O Patient has experienced the defined signs and symptoms of SMA type I, II or IIIa prior to three years of age or	
	Patient is pre-symptomatic	
	O Patient has three or less copies of SMN2	
	TION nent required after 12 months	
	es (tick boxes where appropriate)	
and) There has been demonstrated maintenance of motor milestone function since treatment initiation	
Patient does not require invasive permanent ventilation (at least 16 hours per day), in the absence of a potentially reversible cause while being treated with risdiplam		
and	D Risdiplam not to be administered in combination other SMA disease modifying treatments or gene therapy	

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:

Modafinil

	ATIO	1 – N	Varco	lepsy		
				ired after 24 months		
Prer	equis	ites	(tick b	poxes where appropriate)		
(and				by, or recommended by a neurologist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed Ith NZ Hospital.		
	and	O The patient has a diagnosis of narcolepsy and has excessive daytime sleepiness associated with narcolepsy occurring almost daily for three months or more				
		or	0	The patient has a multiple sleep latency test with a mean sleep latency of less than or equal to 10 minutes and 2 or more sleep onset rapid eye movement periods		
			Ο	The patient has at least one of: cataplexy, sleep paralysis or hypnagogic hallucinations		
	and	_				
		or	Ο	An effective dose of a listed formulation of methylphenidate or dexamphetamine has been trialled and discontinued because of intolerable side effects		
	,		0	Methylphenidate and dexamphetamine are contraindicated		
	TINU	CONTINUATION – Narcolepsy				

Re-assessment required after 24 months Prerequisites (tick box where appropriate)



 \bigcirc

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

The treatment remains appropriate and the patient is benefiting from treatment

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.

PRESC	RIBER	PATIENT:
Name:		Name:
Ward:		NHI:
Methy	Iphenidate hydrochloride	
	TION – ADHD (immediate-release and sustained-release formulation quisites (tick box where appropriate)	ons)
and	Prescribed by, or recommended by a paediatrician or psychiatrist, or Health NZ Hospital.	in accordance with a protocol or guideline that has been endorsed by the
	Patient has ADHD (Attention Deficit and Hyperactivity Disorder), dia	gnosed according to DSM-IV or ICD 10 criteria
Re-as	TION – Narcolepsy (immediate-release and sustained-release form sessment required after 24 months quisites (tick box where appropriate)	ulations)
C		ialist, or in accordance with a protocol or guideline that has been endorsed
and	Patient suffers from narcolepsy	
Re-as	INUATION – Narcolepsy (immediate-release and sustained-release sessment required after 24 months quisites (tick box where appropriate)	formulations)
	Prescribed by, or recommended by a neurologist or respiratory spec by the Health NZ Hospital.	ialist, or in accordance with a protocol or guideline that has been endorsed
and) The treatment remains appropriate and the patient is benefiting from	treatment
	TION – Extended-release and modified-release formulations quisites (tick boxes where appropriate)	
and	Prescribed by, or recommended by a paediatrician or psychiatrist, o Health NZ Hospital.	in accordance with a protocol or guideline that has been endorsed by the
	\bigcirc Patient has ADHD (Attention Deficit and Hyperactivity Disorder and	r), diagnosed according to DSM-IV or ICD 10 criteria
		henidate hydrochloride (immediate-release or sustained-release) which ind/or compliance difficulties
		on or abuse of immediate-release methylphenidate hydrochloride

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	PATIENT:
Name:	Name:
Ward:	NHI:
Dexamphetamine sulphate	
INITIATION – ADHD Prerequisites (tick box where appropriate)	
 Prescribed by, or recommended by a paediatrician or psychiatrist, or Health NZ Hospital. and Patient has ADHD (Attention Deficit and Hyperactivity Disorder), dia 	r in accordance with a protocol or guideline that has been endorsed by the gnosed according to DSM-IV or ICD 10 criteria
INITIATION – Narcolepsy Re-assessment required after 24 months Prerequisites (tick box where appropriate)	
 Prescribed by, or recommended by a neurologist or respiratory spect by the Health NZ Hospital. and Patient suffers from narcolepsy 	ialist, or in accordance with a protocol or guideline that has been endorsed
CONTINUATION – Narcolepsy Re-assessment required after 24 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a neurologist or respiratory spec by the Health NZ Hospital. and O The treatment remains appropriate and the patient is benefiting from	ialist, or in accordance with a protocol or guideline that has been endorsed

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:
Rivastigmine	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O The patient has been diagnosed with dementia and O The patient has experienced intolerable nausea and/or vomitin	ng from donepezil tablets
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
O The treatment remains appropriate	
The patient has demonstrated a significant and sustained ben	efit from treatment

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:
Naltrexone hydrochloride	
INITIATION – Alcohol dependence Prerequisites (tick boxes where appropriate)	
Patient is currently enrolled, or is planned to be enrolled, in a rand And Naltrexone is to be prescribed by, or on the recommendation of the prescribed by and the prescribed by an and the prescribed by an and the prescribed by an	recognised comprehensive treatment programme for alcohol dependence of, a physician working in an Alcohol and Drug Service
INITIATION – Constipation Prerequisites (tick box where appropriate) O For the treatment of opioid-induced constipation	

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.

PRES	CRI	BER		PATIENT:
Name	:			Name:
Ward:				NHI:
Nico	tine	9		
INITI Prere			(tick boxes where appropriate)	
	•	0	For perioperative use in patients who have a 'nil by mouth' inst	truction
	or	Ο	For use within mental health inpatient units	
	or	Ο	Patient would be admitted to a mental health inpatient unit, but	t is unable to due to COVID-19 self-isolation requirement
	or	0	For acute use in agitated patients who are unable to leave the	hospital facilities

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:	

Varenicline

NITIATION Prerequisites (tick boxes where appropriate)		
	0	Short-term therapy as an aid to achieving abstinence in a patient who has indicated that they are ready to cease smoking
and	0	The patient is part of, or is about to enrol in, a comprehensive support and counselling smoking cessation programme, which includes prescriber or nurse monitoring
		O The patient has tried but failed to quit smoking after at least two separate trials of nicotine replacement therapy, at least one of which included the patient receiving comprehensive advice on the optimal use of nicotine replacement therapy
	or	O The patient has tried but failed to quit smoking using bupropion or nortriptyline
and	Ο	The patient has not had a Special Authority for varenicline approved in the last 6 months
and	Ο	Varenicline is not to be used in combination with other pharmacological smoking cessation treatments and the patient has agreed to this
	Ο	The patient is not pregnant
and	Ο	The patient will not be prescribed more than 12 weeks' funded varenicline in a 12 month period

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:
Buprenorphine with naloxone	
INITIATION - Detoxification Prerequisites (tick boxes where appropriate) O Patient is opioid dependent and O Patient is currently engaged with an opioid treatment service approved by the Ministry of Health O Prescriber works in an opioid treatment service approved by the Ministry of Health	
INITIATION – Maintenance treatment Prerequisites (tick boxes where appropriate)	
O Patient is opioid dependent	
Patient will not be receiving methadone and	
O Patient is currently enrolled in an opioid substitution treatment	program in a service approved by the Ministry of Health
O Prescriber works in an opioid treatment service approved by the	he Ministry of Health

Oncology Agents and Immunosuppressants

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:	

Bendamustine hydrochloride

 	reatment naive CLL (tick boxes where appropriate)
Ο	The patient has Binet stage B or C, or progressive stage A chronic lymphocytic leukaemia requiring treatment
and	The patient is chemotherapy treatment naive
and	The patient is unable to tolerate toxicity of full-dose FCR
and O and	Patient has ECOG performance status 0-2
and	Patient has a Cumulative Illness Rating Scale (CIRS) score of < 6
	Bendamustine is to be administered at a maximum dose of 100 mg/m ² on days 1 and 2 every 4 weeks for a maximum of 6 cycles

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL). Chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments.

INITIATION – Indolent, Low-grade lymphomas Re-assessment required after 9 months

Prerequisites (tick boxes where appropriate)

nd	Patient has a WHO performance status of 0-2
	O Patient is treatment naive
	Bendamustine is to be administered for a maximum of 6 cycles (in combination with rituximab when CD20+)
or	
	O Patient is refractory to or has relapsed within 12 months of a rituximab containing combined chemo-immunotherapy regimen
	and O Bendamustine is to be administered in combination with obinutuzumab for a maximum of 6 cycles
or	
	O The patient has not received prior bendamustine therapy and
	O Bendamustine is to be administered for a maximum of 6 cycles in relapsed patients (in combination with rituximab when CD20+)
	and O Patient has had a rituximab treatment-free interval of 12 months or more

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	PATIENT:
Name:	Name:
Ward:	NHI:
Bendamustine hydrochloride - continued	
CONTINUATION – Indolent, Low-grade lymphomas Re-assessment required after 9 months	
Prerequisites (tick boxes where appropriate)	
O Patient is refractory to or has relapsed within 12 months	of rituximab in combination with bendamustine

or	O Bendamustine is to be administered in combination with obinutuzumab for a maximum of 6 cycles O Patients have not received a bendamustine regimen within the last 12 months
	and Bendamustine is to be administered for a maximum of 6 cycles in relapsed patients (in combination with rituximab when CD20+) and O Patient has had a rituximab treatment-free interval of 12 months or more
Neter in	or O Bendamustine is to be administered as a monotherapy for a maximum of 6 cycles in rituximab refractory patients
	dolent, low-grade lymphomas' includes follicular, mantle cell, marginal zone and lymphoplasmacytic/ Waldenström's macroglobulinaemia.
Re-asses	ON – Hodgkin's lymphoma* ssment required after 6 months isites (tick boxes where appropriate)
	O Patient has Hodgkin's lymphoma requiring treatment

	\mathbf{O}	Patient has Hodgkin's lymphoma requiring treatment	
	and	Patient has a ECOG performance status of 0-2	
	and	Patient has a ECOG performance status of 0-2	
	\bigcirc	Patient has received one prior line of chemotherapy	
	and		
	and	Patient's disease relapsed or was refractory following prior chemotherapy	
	O	Bendamustine is to be administered in combination with gemcitabine and vinorelbine (BeGeV) at a maximum dose of no greater than	
		90 mg/m2 twice per cycle, for a maximum of four cycles	
Noto	to: Indiantiana markad with * ara unapproved indiantiana		

Note: Indications marked with * are unapproved indications.

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:

Azacitidine

Re-	INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)					
and			cribed ital.	by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ		
		or or	0 0 0	The patient has International Prognostic Scoring System (IPSS) intermediate-2 or high risk myelodysplastic syndrome The patient has chronic myelomonocytic leukaemia (10%-29% marrow blasts without myeloproliferative disorder) The patient has acute myeloid leukaemia with 20-30% blasts and multi-lineage dysplasia, according to World Health Organisation Classification (WHO)		
	and and	Ο		patient has performance status (WHO/ECOG) grade 0-2 patient has an estimated life expectancy of at least 3 months		
			DN			

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

and \bigcirc

O No evidence of disease progression

The treatment remains appropriate and patient is benefitting from treatment

I confirm that the above details are correct:

Signed: Date:

Form RS159 July 2024	Form RS1596 HOSPITAL MEDICINES LIST Page uly 2024 RESTRICTIONS CHECKLIST Page				
	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	PRESCRIBER PATIENT:				
Name:		Name:			
Ward:		NHI:			
Pemetrexed					
	lesothelioma required after 8 months tick boxes where appropriate)				
and	Patient has been diagnosed with mesothelioma Pemetrexed to be administered at a dose of 500 mg/m ² every 2 6 cycles	21 days in combination with cisplatin or carboplatin for a maximum of			
Re-assessment	N – Mesothelioma required after 8 months tick boxes where appropriate)				
and	No evidence of disease progression The treatment remains appropriate and the patient is benefittin	g from treatment			

 \bigcirc Pemetrexed to be administered at a dose of 500mg/m² every 21 days for a maximum of 6 cycles

Re-a	ssessi	ment r	equired at	eell lung cancer fter 8 months where appropriate)
	(and	D P	atient has	s locally advanced or metastatic non-squamous non-small cell lung carcinoma Patient has chemotherapy-naïve disease
		or	0	Pemetrexed is to be administered at a dose of 500 mg/m ² every 21 days in combination with cisplatin or carboplatin for a maximum of 6 cycles Patient has had first-line treatment with platinum based chemotherapy
			and and	Patient has not received prior funded treatment with pemetrexed Pemetrexed is to be administered at a dose of 500 mg/m ² every 21 days for a maximum of 6 cycles

CONTINUATION - Non small cell lung cancer

and

Re-assessment required after 8 months Prerequisites (tick boxes where appropriate)

No evidence of disease progression \bigcirc and The treatment remains appropriate and the patient is benefitting from treatment \bigcirc and O Pemetrexed is to be administered at a dose of 500mg/m² every 21 days

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:
Mercaptopurine	
INITIATION Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a paediatric haematologist or pabeen endorsed by the Health NZ Hospital. and O The patient requires a total dose of less than one full 50 mg tablet p	ediatric oncologist, or in accordance with a protocol or guideline that has er day
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a paediatric haematologist or paediateneous been endorsed by the Health NZ Hospital. and O The patient requires a total dose of less than one full 50 mg tablet p	ediatric oncologist, or in accordance with a protocol or guideline that has er day

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:

Lenalidomide

ΙΝΙΤΙ	INITIATION – Relapsed/refractory disease				
Re-assessment required after 6 months					
Prer	Prerequisites (tick boxes where appropriate)				
(and	D Pres Hos	cribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ bital.			
	and and	Patient has relapsed or refractory multiple myeloma with progressive disease Patient has not previously been treated with lenalidomide			
	01	O Lenalidomide to be used as third line* treatment for multiple myeloma			
		O Lenalidomide to be used as second line treatment for multiple myeloma and			
		O The patient has experienced severe (grade 3 or higher), dose limiting, peripheral neuropathy with either bortezomib or thalidomide that precludes further treatment with either of these treatments			
	and				
	0	Lenalidomide to be administered at a maximum dose of 25 mg/day in combination with dexamethasone			
		DN – Relapsed/refractory disease			
		trequired after 6 months			
Prer	equisites	(tick boxes where appropriate)			
) and	D Pres Hos	cribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ bital.			
and	and	No evidence of disease progression			
	O	The treatment remains appropriate and patient is benefitting from treatment			
		Maintenance following first-line autologous stem cell transplant (SCT) nt required after 6 months			
		(tick boxes where appropriate)			
	~				
)) Pres Hos	cribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ pital.			
and					
	and	Patient has newly diagnosed symptomatic multiple myeloma and has undergone first-line treatment that included an autologous stem cell transplantation			
	and	Patient has at least a stable disease response in the first 100 days after transplantation			
	O and	Lenalidomide maintenance is to be commenced within 6 months of transplantation			
	\bigcirc	Lenalidomide to be administered at a maximum dose of 15 mg/day			

HOSPITAL MEDICINES LIST

July 2	024		RESTRICTIONS CHECKLIST		
Jse th Sched	is checklule. For a	ist to determine if a patient meets the restrict community funding, see the Special Authorit	tions for funding in the hospital setting . For more details, refer to Section H of the Pharmaceutica ty Criteria.		
PRES	CRIBER	1	PATIENT:		
lame	:		Name:		
Vard:			NHI:		
ena	lidomi	de - continued			
Re-a	ssessme	ON – Maintenance following first-line auton nt required after 6 months (tick boxes where appropriate)	ologous stem cell transplant (SCT)		
(and	D Pres	 Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. 			
	Ο	No evidence of disease progression			
	and	The treatment remains appropriate and pa	atient is benefitting from treatment		
a kn regi	own ther men, ste	apeutic chemotherapy regimen and support	n. A line of treatment is considered to comprise either: a) ive treatments or b) a transplant induction chemotherapy tments. Prescriptions must be written by a registered ime operated by the supplier.		

July 2024	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	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Venetoclax				
INITIATION – relapsed/refractory chronic lymphocytic Re-assessment required after 7 months Prerequisites (tick boxes where appropriate)	leukaemia			
O Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				

	O	Patient has chronic lymphocytic leukaemia requiring treatment
	and	Patient has received at least one prior therapy for chronic lymphocytic leukaemia
	and	
	and	Patient has not previously received funded venetoclax
	O	The patient's disease has relapsed within 36 months of previous treatment
	and	Venetoclax to be used in combination with six 28-day cycles of rituximab commencing after the 5-week dose titration schedule with
		venetoclax to be used in combination with six 26-day cycles of nuximab commencing after the 5-week dose titration schedule with venetoclax
	and	Patient has an ECOG performance status of 0-2
	requisites	nt required after 6 months (tick boxes where appropriate) cribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ bital.
	0	Treatment remains clinically appropriate and the patient is benefitting from and tolerating treatment
	and	Venetoclax is to be discontinued after a maximum of 24 months of treatment following the titration schedule unless earlier discontinuation is required due to disease progression or unacceptable toxicity
	IATION -	previously untreated chronic lymphocytic leukaemia with 17p deletion or TP53 mutation*
Re-a		nt required after 6 months
		(tick boxes where appropriate)

\mathbf{O}	Prescribed by, or recommended	ed by a haematologist, or i	in accordance with a	a protocol or guideline that l	has been endorsed by the Health	NZ
	Hospital.					
and						

O Patient has previously untreated chronic lymphocytic leukaemia

 $m O\,$ There is documentation confirming that patient has 17p deletion by FISH testing or TP53 mutation by sequencing

O Patient has an ECOG performance status of 0-2

CONTINUATION - previously untreated chronic lymphocytic leukaemia with 17p deletion or TP53 mutation*

Re-assessment required after 6 months **Prerequisites** (tick box where appropriate)

and

and

O Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

Ć	ノ Th	ne treatment remains clinically appropriate and the patient is benefitting from and tolerating treatment
Note:	'Chro	onic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL)* and B-cell prolymphocytic leukaemia (B-PLL)*. Indications
marke	ed with	n * are unapproved indications.

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	PATIENT:
Name:	Name:
Ward:	NHI:

Olaparib

		Dvarian cancer t required after 12 months
Prerequis	ites	(tick boxes where appropriate)
	Presc Hospi	cribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.
and	0	Patient has a high-grade serous* epithelial ovarian, fallopian tube, or primary peritoneal cancer
and	\bigcirc	There is documentation confirming pathogenic germline BRCA1 or BRCA2 gene mutation
		O Patient has newly diagnosed, advanced disease
		O Patient has received one line** of previous treatment with platinum-based chemotherapy and
		O Patient's disease must have experienced a partial or complete response to the first-line platinum-based regimen
	or	
		O Patient has received at least two lines** of previous treatment with platinum-based chemotherapy and
		O Patient has platinum sensitive disease defined as disease progression occurring at least 6 months after the last dose of the penultimate line** of platinum-based chemotherapy
		and
		O Patient's disease must have experienced a partial or complete response to treatment with the immediately preceding platinum-based regimen
		and
		O Patient has not previously received funded olaparib treatment
and	\square	
and	Ο	Treatment will be commenced within 12 weeks of the patient's last dose of the immediately preceding platinum-based regimen
	Ο	Treatment to be administered as maintenance treatment
and	Ο	Treatment not to be administered in combination with other chemotherapy

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.

PRES	CRIB	ER			PATIENT:
Name	:				Name:
Ward:					NHI:
Olap	arib	- CO	ntinue	ed	
Re-a	ssess equisi	men ites	t requ (tick b ribed	Ovarian cancer ired after 12 months ioxes where appropriate) by, or recommended by a medical oncologist, or in accord	ance with a protocol or guideline that has been endorsed by the Health NZ
and	(and			ment remains clinically appropriate and patient is benefittir	ng from treatment
		or	0 0	No evidence of progressive disease Evidence of residual (not progressive) disease and the pa opinion	atient would continue to benefit from treatment in the clinician's
	and (and (and	о о		ment to be administered as maintenance treatment ment not to be administered in combination with other che	motherapy
		or	an	O Documentation confirming that the patient has been	nt with platinum-based chemotherapy n informed and acknowledges that the funded treatment period of patient experiences a complete response to treatment and there is
			Ο	Patient has received at least two lines** of previous treatment	nent with platinum-based chemotherapy

Note: *Note "high-grade serous" includes tumours with high-grade serous features or a high-grade serous component **A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments.

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:
Ibrutinib	

) and	Patient has chronic lymphocytic leukaemia (CLL) requiring therapy
Ο	Patient has not previously received funded ibrutinib
and O and	Ibrutinib is to be used as monotherapy
	O There is documentation confirming that patient has 17p deletion or TP53 mutation and
	O Patient has experienced intolerable side effects with venetoclax monotherapy
no	O Patient has received at least one prior immunochemotherapy for CLL
	and O Patient's CLL has relapsed within 36 months of previous treatment and
	O Patient has experienced intolerable side effects with venetoclax in combination with rituximab regimen
o	O Patient's CLL is refractory to or has relapsed within 36 months of a venetoclax regimen
	ON – chronic lymphocytic leukaemia (CLL)
sessme	nt required after 12 months (tick boxes where appropriate)

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL) and B-cell prolymphocytic leukaemia (B-PLL)*. Indications marked with * are Unapproved indications.

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:

Niraparib

	smer	t required after 6 months (tick boxes where appropriate)	
and	O	Patient has advanced high-grade serous* epithelial ovarian, fallopian tube, or primary peritoneal cancer	
and	Ο	Patient has received at least one line** of treatment with platinum-based chemotherapy	
and	Ο	Patient has experienced a partial or complete response to the preceding treatment with platinum-based chemotherapy	
and	Ο	Patient has not previously received funded treatment with a PARP inhibitor	
	or	O Treatment will be commenced within 12 weeks of the patient's last dose of the preceding platinum-based regimen	
		O Patient commenced treatment with niraparib prior to 1 May 2024	
and	0	Treatment to be administered as maintenance treatment	
	0	Treatment not to be administered in combination with other chemotherapy	
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)			
and	0	No evidence of progressive disease	
and	Ο	Treatment to be administered as maintenance treatment	
and	Ο	Treatment not to be administered in combination with other chemotherapy	
		O Treatment with niraparib to cease after a total duration of 36 months from commencement	
	or	O Treatment with niraparib is being used in the second-line or later maintenance setting	

Note: * "high-grade serous" includes tumours with high-grade serous features or a high-grade serous component. **A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments

Form RS1994 July 2024	HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST	Page 2
Use this checklist to determine if a patient meets the restr Schedule. For community funding, see the Special Autho	rictions for funding in the hospital setting . For more details, refer to prity Criteria.	o Section H of the Pharmaceutical
PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Temozolomide		
INITIATION – gliomas Re-assessment required after 12 months		
Prerequisites (tick box where appropriate)		
O Patient has a glioma		
CONTINUATION – gliomas Re-assessment required after 12 months Prerequisites (tick box where appropriate)		
O Treatment remains appropriate and patient is t	benefitting from treatment	
INITIATION – Neuroendocrine tumours Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)		
and Temozolomide is to be given in combina and	reatment cycles for a maximum of 5 days treatment per cycle at a r	maximum dose of 200 mg/m ²
CONTINUATION – Neuroendocrine tumours Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)		
O No evidence of disease progression		
The treatment remains appropriate and	the patient is benefitting from treatment	
INITIATION – ewing's sarcoma Re-assessment required after 9 months Prerequisites (tick box where appropriate) O Patient has relapse or refractory Ewing's sarco	oma	
CONTINUATION – ewing's sarcoma		
Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)		
O No evidence of disease progression		
The treatment remains appropriate and	the patient is benefitting from treatment	
)

Note: Indication marked with a * is an unapproved indication. Temozolomide is not funded for the treatment of relapsed high grade glioma.

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	PATIENT:
Name:	Name:
Ward:	NHI:
Thalidomide	
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O The patient has multiple myeloma or O The patient has systemic AL amyloidosis*	
O The patient has erythema nodosum leprosum	
CONTINUATION Prerequisites (tick box where appropriate)	

O Patient has obtained a response from treatment during the initial approval period Note: Prescription must be written by a registered prescriber in the thalidomide risk management programme operated by the supplier Maximum dose of 400 mg daily as monotherapy or in a combination therapy regimen Indication marked with * is an unapproved indication

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.

PRES	SCR	IBER		PATIENT:
Name	Name:			Name:
Ward:			NHI:	
Bort	ezc	mib		
			multiple myeloma/amyloidosis (tick boxes where appropriate)	
		0	The patient has symptomatic multiple myeloma	
	or	Ο	The patient has symptomatic systemic AL amyloidosis	

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:
Pegaspargase	
INITIATION – Newly diagnosed ALL Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O The patient has newly diagnosed acute lymphoblastic leukaer	nia
and O Pegaspargase to be used with a contemporary intensive multi	
INITIATION – Relapsed ALL Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
O The patient has relapsed acute lymphoblastic leukaemia and O Pegaspargase to be used with a contemporary intensive multi	-agent chemotherapy treatment protocol
INITIATION – Lymphoma Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Patient has lymphoma requiring L-asparaginase containing protocol	(e.g. SMILE)

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.

PRESC	RIBER	PATIENT:
Name:		Name:
Ward:		NHI:

Nilotinib

Re-a		N ment required after 6 months ites (tick boxes where appropriate)	
(and	O Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
	(and	O Patient has a diagnosis of chronic myeloid leukaemia (CML) in blast crisis, high risk chronic phase, or in chronic phase	
		O Patient has documented CML treatment failure* with a tyrosine kinase inhibitor (TKI)	
		O Patient has experienced treatment limiting toxicity with a tyrosine kinase inhibitor (TKI) precluding further treatment	
	and (and	O Maximum nilotinib dose of 800 mg/day	
		O Subsidised for use as monotherapy only	
Note	: *trea	atment failure as defined by Leukaemia Net Guidelines.	
Re-a	ssess	ATION ment required after 6 months ites (tick boxes where appropriate)	
(and		Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ dospital.	
	(and	m O Lack of treatment failure while on nilotinib as defined by Leukaemia Net Guidelines	
	and (m O Nilotinib treatment remains appropriate and the patient is benefiting from treatment	
	and (O Maximum nilotinib dose of 800 mg/day	
	and	O Subsidised for use as monotherapy only	

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:

Ruxolitinib

	ssess equis	smen ites	t required after 12 months (tick boxes where appropriate) cribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.
	and	O	The patient has primary myelofibrosis or post-polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis A classification of risk of intermediate-2 or high-risk myelofibrosis according to either the International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or the Age-Adjusted DIPSS A classification of risk of intermediate-1 myelofibrosis according to either the International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or the Age-Adjusted DIPSS A classification of risk of intermediate-1 myelofibrosis according to either the International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or the Age-Adjusted DIPSS A classification of risk of intermediate-1 myelofibrosis according to either the International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or the Age-Adjusted DIPSS A patient has severe disease-related symptoms that are resistant, refractory or intolerant to available therapy
	and	0	A maximum dose of 20 mg twice daily is to be given
CON Re-a			DN It required after 12 months

Prerequisites (tick boxes where appropriate)

and

A maximum dose of 20 mg twice daily is to be given

The treatment remains appropriate and the patient is benefiting from treatment

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:
Alectinib	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Patient has locally advanced, or metastatic, unresectable, non and O There is documentation confirming that the patient has an ALH and O Patient has an ECOG performance score of 0-2	a-small cell lung cancer K tyrosine kinase gene rearrangement using an appropriate ALK test
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O No evidence of progressive disease according to RECIST crite and O The patient is benefitting from and tolerating treatment	eria

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:	

Palbociclib (Ibrance)

		С	Patient has unresectable locally advanced or metastatic breast cancer
	and	С	There is documentation confirming disease is hormone-receptor positive and HER2-negative
	and (С	Patient has an ECOG performance score of 0-2
		or	O Disease has relapsed or progressed during prior endocrine therapy
		01	O Patient is amenorrhoeic, either naturally or induced, with endocrine levels consistent with a postmenopausal or without menstrual-potential state
			O Patient has not received prior systemic treatment for metastatic disease
	and (and		Treatment must be used in combination with an endocrine partner Patient has not received prior funded treatment with a CDK4/6 inhibitor
or	()	Patient has an active Special Authority approval for ribociclib
	and	С	Patient has experienced a grade 3 or 4 adverse reaction to ribociclib that cannot be managed by dose reductions and requires treatment discontinuation
	(С	Treatment must be used in combination with an endocrine partner
	and (С	There is no evidence of progressive disease since initiation of ribociclib

Prerequisites (tick boxes where appropriate)

Ο and \bigcirc

Treatment must be used in combination with an endocrine partner

There is no evidence of progressive disease since initiation of palbociclib

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.

PRES	CRIBER		PATIENT:
Name:			Name:
Ward:			NHI:
Mido	staurin		
Prere	ATION quisites and and and and and	(tick boxes where appropriate) Patient has a diagnosis of acute myeloid leukaemia Condition must be FMS tyrosine kinase 3 (FLT3) mutation pos Patient must not have received a prior line of intensive chemot Patient is to receive standard intensive chemotherapy in comb	herapy for acute myeloid leukaemia
	O	Midostaurin to be funded for a maximum of 4 cycles	

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:

Ribociclib

INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)			
and		Patient has unresectable locally advanced or metastatic breast cancer There is documentation confirming disease is hormone-receptor positive and HER2-negative Patient has an ECOG performance score of 0-2	
	or	 O Disease has relapsed or progressed during prior endocrine therapy O Patient is amenorrhoeic, either naturally or induced, with endocrine levels consistent with a postmenopausal or without menstrual-potential state and O Patient has not received prior systemic endocrine treatment for metastatic disease 	
and	O	O Patient commenced treatment with ribociclib in combination with an endocrine partner prior to 1 July 2024 and O There is no evidence of progressive disease Treatment to be used in combination with an endocrine partner Patient has not received prior funded treatment with a CDK4/6 inhibitor	
or and and		Patient has an active Special Authority approval for palbociclib Patient has experienced a grade 3 or 4 adverse reaction to palbociclib that cannot be managed by dose reductions and requires treatment discontinuation Treatment must be used in combination with an endocrine partner There is no evidence of progressive disease since initiation of palbociclib	
Prerequisites	t requ (tick b Treat	aired after 12 months poxes where appropriate) ament must be used in combination with an endocrine partner e is no evidence of progressive disease since initiation of ribociclib	

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 th	e Pharmaceutical
Schedule. For community funding, see the Special Authority Criteria.			

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Dasatinib	
NITIATION	

	Prescribed by, or recommended by a haematologist or any relevant practitioner on the recommendation of a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
	O The patient has a diagnosis of chronic myeloid leukaemia (CML) in blast crisis or accelerated phase and O Maximum dose of 140 mg/day		
or			
	The patient has a diagnosis of Philadelphia chromosome-positive acute lymphoid leukaemia (Ph+ ALL) Maximum dose of 140 mg/day		
or			
	O The patient has a diagnosis of CML in chronic phase and		
	O Maximum dose of 100 mg/day and		
	O Patient has documented treatment failure* with imatinib		
	Patient has experienced treatment-limiting toxicity with imatinib precluding further treatment with imatinib		
	or O Patient has high-risk chronic-phase CML defined by the Sokal or EURO scoring system		
	O Patients is enrolled in the KISS study** and requires dasatinib treatment according to the study protocol		

CONTINUATION

and

and

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

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

O Lack of treatment failure while on dasatinib*

Dasatinib treatment remains appropriate and the patient is benefiting from treatment

O Maximum dasatinib dose of 140 mg/day for accelerated or blast phase CML and Ph+ ALL, and 100 mg/day for chronic phase CML

Note: *treatment failure for CML as defined by Leukaemia Net Guidelines. **Kinase-Inhibition Study with Sprycel Start-up https://www.cancertrialsnz.ac.nz/kiss/

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:

Erlotinib

INITIATION Re-assessment required after 4 months			
Prerequisites (tick boxes where appropriate)			
O Patient has locally advanced or metastatic, unresectable, non-squamous Non Small Cell Lung Cancer (NSCLC) and O There is documentation confirming that the disease expresses activating mutations of EGFR tyrosine kinase and			
O Patient is treatment naive			
O The patient has discontinued getitinib due to intolerance			
O The cancer did not progress while on gefitinib			
and O Erlotinib is to be given for a maximum of 3 months			
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)			
O Radiological assessment (preferably including CT scan) indicates NSCLC has not progressed and			
C Erlotinib is to be given for a maximum of 3 months			
CONTINUATION – pandemic circumstances Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)			
O The patient is clinically benefiting from treatment and continued treatment remains appropriate and			
O Erlotinib to be discontinued at progression			
The regular renewal requirements cannot be met due to COVID-19 constraints on the health sector			

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	R P/	ATIENT:
Name:	Na	ame:
Ward:	NI	HI:
Sunitinib		
	 – RCC ent required after 3 months es (tick boxes where appropriate) The patient has metastatic renal cell carcinoma 	
0	 O The patient is treatment naive O The patient has only received prior cytokine treatment O The patient has only received prior treatment with an invest has Ethics Committee approval O The patient has discontinued pazopanib within 3 mor and O The cancer did not progress whilst on pazopanib 	igational agent within the confines of a bona fide clinical trial which
and and and	 The patient has good performance status (WHO/ECOG grade 0-2 The disease is of predominant clear cell histology 	2)

C Karnofsky performance score of less than or equal to 70 and

J Haemoglobin level < lower limit of normal

O 2 or more sites of organ metastasis

J Sunitinib to be used for a maximum of 2 cycles

Note: RCC - Sunitinib treatment should be stopped if disease progresses. Poor prognosis patients are defined as having at least 3 of criteria 5.1-5.6. Intermediate prognosis patients are defined as having 1 or 2 of criteria 5.1-5.6.

CONTINUATION - RCC

О

and

and

Re-assessment required after 3 months

 \bigcirc

and

and

and

and

Prerequisites (tick boxes where appropriate)

No evidence of disease progression

The treatment remains appropriate and the patient is benefiting from treatment

Lactate dehydrogenase level > 1.5 times upper limit of normal

Interval of < 1 year from original diagnosis to the start of systemic therapy

Corrected serum calcium level > 10 mg/dL (2.5 mmol/L)

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	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Sunitinib - continued		

INITIATION - GIST

Re-a		nt requ	uired after 3 months boxes where appropriate)
	and	The	patient has unresectable or metastatic malignant gastrointestinal stromal tumour (GIST)
		0	The patient's disease has progressed following treatment with imatinib
	01	0	The patient has documented treatment-limiting intolerance, or toxicity to, imatinib

CONTINUATION – GIST

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

The patient has responded to treatment or has stable disease as determined by Choi's modified CT response evaluation criteria as follows:

 O
 The patient has had a complete response (disappearance of all lesions and no new lesions)

 or
 O

 or
 The patient has had a partial response (a decrease in size of 10% or more or decrease in tumour density in Hounsfield Units (HU) of 15% or more on CT and no new lesions and no obvious progression of non-measurable disease)

 or
 O

 or
 The patient has stable disease (does not meet criteria the two above) and does not have progressive disease and no symptomatic deterioration attributed to tumour progression

 and
 O

 The treatment remains appropriate and the patient is benefiting from treatment

CONTINUATION – GIST pandemic circumstances

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

and

and

and

m O The patient has unresectable or metastatic malignant gastrointestinal stromal tumour (GIST)

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

O Sunitinib is to be discontinued at progression

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

Note: GIST - It is recommended that response to treatment be assessed using Choi's modified CT response evaluation criteria (J Clin Oncol, 2007, 25:1753-1759). Progressive disease is defined as either: an increase in tumour size of 10% or more and not meeting criteria of partial response (PR) by tumour density (HU) on CT; or: new lesions, or new intratumoral nodules, or increase in the size of the existing intratumoral nodules.

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.

PRESCR	IBER	PATIENT:
Name:		Name:
Ward:		NHI:
Lapatin	ib	
INITIATI Prerequ	ON isites (tick box where appropriate) For continuation use only	
	UATION ssment required after 12 months isites (tick boxes where appropriate)	
an	O The cancer has not progressed at any time point during the pr	
an	O Lapatinib not to be given in combination with trastuzumab	

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:
Pazopanib	
	required after 3 months ck boxes where appropriate)
and T	The patient has metastatic renal cell carcinoma
or (The patient is treatment naive The patient has only received prior cytokine treatment O The patient has discontinued sunitinib within 3 months of starting treatment due to intolerance
and O T	and O The cancer did not progress whilst on sunitinib The patient has good performance status (WHO/ECOG grade 0-2) The disease is of predominant clear cell histology
and (and (and (and (and (and (and	 Lactate dehydrogenase level > 1.5 times upper limit of normal Haemoglobin level < lower limit of normal Corrected serum calcium level > 10 mg/dL (2.5 mmol/L) Interval of < 1 year from original diagnosis to the start of systemic therapy Karnofsky performance score of less than or equal to 70 2 or more sites of organ metastasis
Prerequisites (tio	required after 3 months ck boxes where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

Note: Pazopanib treatment should be stopped if disease progresses. Poor prognosis patients are defined as having at least 3 of criteria 5.1-5.6. Intermediate prognosis patients are defined as having 1 or 2 of criteria 5.1-5.6.

and

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:	

Gefitinib

(
	ent required after 4 months
	s (tick boxes where appropriate)
Fielequisites	s (lick boxes where appropriate)
and	Patient has locally advanced, or metastatic, unresectable, non-squamous Non Small Cell Lung Cancer (NSCLC)
o	O Patient is treatment naive
	O The patient has discontinued erlotinib due to intolerance
	O The cancer did not progress whilst on erlotinib
and and	There is documentation confirming that disease expresses activating mutations of EGFR tyrosine kinase
	Gefitinib is to be given for a maximum of 3 months
CONTINUAT	
	ent required after 6 months
Prerequisites	s (tick boxes where appropriate)
U O	Radiological assessment (preferably including CT scan) indicates NSCLC has not progressed
and	Gefitinib is to be given for a maximum of 3 months
	ION – pandemic circumstances ent required after 6 months
	s (tick boxes where appropriate)
and	The patient is clinically benefiting from treatment and continued treatment remains appropriate
and	Gefitinib to be discontinued at progression
	The regular renewal requirements cannot be met due to COVID-19 constraints on the health sector

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:
Dexrazoxane	

	quisi		(tick boxes where appropriate)
(and			bribed by, or recommended by a medical oncologist, paediatric oncologist, haematologist or paediatric haematologist, or in accordance with tocol or guideline that has been endorsed by the Health NZ Hospital.
	(С	Patient is to receive treatment with high dose anthracycline given with curative intent
	and (С	Based on current treatment plan, patient's cumulative lifetime dose of anthracycline will exceed 250mg/m2 doxorubicin equivalent or greater
	and (and	С	Dexrazoxane to be administered only whilst on anthracycline treatment
		~	O Treatment to be used as a cardioprotectant for a child or young adult
		or	O Treatment to be used as a cardioprotectant for secondary malignancy

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:	

Abiraterone acetate

INITIATI Re-asse		nt required	d after 6 months
Prerequ	isites	(tick boxe	es where appropriate)
O			or recommended by a medical oncologist, radiation oncologist or urologist, or in accordance with a protocol or guideline that has d by the Health NZ Hospital.
an	O d	Patient I	has prostate cancer
	O	Patient h	nas metastases
an	Ο	Patient's	disease is castration resistant
		and	Patient is symptomatic
		and	D Patient has disease progression (rising serum PSA) after second line anti-androgen therapy
		and	Patient has ECOG performance score of 0-1
			D Patient has not had prior treatment with taxane chemotherapy
	or	and	Patient's disease has progressed following prior chemotherapy containing a taxane
) Patient has ECOG performance score of 0-2
		and	D Patient has not had prior treatment with abiraterone
\Box			

CONTINUATION

CONTINUATION
Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)

and			cribed by, or recommended by a medical oncologist, radiation oncologist or urologist, or in accordance with a protocol or guideline that has endorsed by the Health NZ Hospital.
		Ο	Significant decrease in serum PSA from baseline
	and	d O	No evidence of clinical disease progression
	and	d O	No initiation of taxane chemotherapy with abiraterone
	and	0	The treatment remains appropriate and the patient is benefiting from treatment

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:
Abiraterone acetate - continued	
CONTINUATION – pandemic circumstances Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
The patient is clinically benefiting from treatment and continue	ed treatment remains appropriate
O Abiraterone acetate to be discontinued at progression	
And O No initiation of taxane chemotherapy with abiraterone and _	
\bigcirc The regular renewal requirements cannot be met due to COVI	D-19 constraints on the health sector

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:

Fulvestrant

NITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)
O Prescribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health N
Hospital.
O Patient has oestrogen-receptor positive locally advanced or metastatic breast cancer and
 Patient has disease progression following prior treatment with an aromatase inhibitor or tamoxifen for their locally advanced or metastatic disease and
O Treatment to be given at a dose of 500 mg monthly following loading doses
O Treatment to be discontinued at disease progression

CONTINUATION

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

O Prescribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed Hospital.		Prescribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	an	O Treatment remains appropriate and patient is benefitting from treatment
	an	O Treatment to be given at a dose of 500 mg monthly
	an	O No evidence of disease progression

I confirm that the above of	details are correct:
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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:

Octreotide

INITIATION – Malignant bowel obstruction Prerequisites (tick boxes where appropriate)				
	atient has nausea* and vomiting* due to malignant bowel obstruction*			
and O Treatr and	ment with antiemetics, rehydration, antimuscarinic agents, corticosteroids and analgesics for at least 48 hours has failed			
\sim	otide to be given at a maximum dose 1500 mcg daily for up to 4 weeks			
Note: Indications man	rked with * are unapproved indications			
INITIATION – acromegaly Re-assessment required after 3 months Prerequisites (tick boxes where appropriate)				
O The p	atient has acromegaly			
	Treatment with surgery, radiotherapy and a dopamine agonist has failed			
or O	Treatment with octreotide is for an interim period while awaiting the effects of radiotherapy and a dopamine agonist has failed			
	The patient is unwilling, or unable, to undergo surgery and/or radiotherapy			
CONTINUATION – acromegaly				

Prerequisites (tick boxes where appropriate)

and

()

O IGF1 levels have decreased since starting octreotide

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:

and)

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	PATIENT:
Name:	Name:
Ward:	NHI:
Octreotide - continued	
	Il in order to improve their clinical state prior to definitive surgery
or and O Gastrinoma and O Patient has failed surgery or O Patient in metastatic disease after H2 antagonists	e (or proton pump inhibitors) have failed
or O Insulinomas	

			O Surgery is contraindicated or has failed
	or (or	С ғ	For pre-operative control of hypoglycaemia and for maintenance therapy
		and	O Carcinoid syndrome (diagnosed by tissue pathology and/or urinary 5HIAA analysis)
		anu	O Disabling symptoms not controlled by maximal medical therapy
Note:	restr	iction	n applies only to the long-acting formulations of octreotide
Re-as	sessi	nent	t required after 12 months (tick boxes where appropriate)
	(C F	Patient has acromegaly
	and (and	D F	Patient has a large pituitary tumour, greater than 10 mm at its widest
	(D F	Patient is scheduled to undergo pituitary surgery in the next six months
Note:	Indic	ation	ns marked with * are unapproved indications
			N – Acromegaly - pandemic circumstances t 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 O The regular renewal requirements cannot be met due to COVID-19 constraints on the health sector

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.

PRESCRI	BER	PATIENT:	
Name:		Name:	
Ward:		NHI:	
Aminole	evulinic acid hydrochloride		
INITIATION – high grade malignant glioma Prerequisites (tick boxes where appropriate)			
and	O Patient has newly diagnosed, untreated, glioblastoma multiform	ne	
	O Treatment to be used as adjuvant to fluorescence-guided rese	ction	
and	O Patient's tumour is amenable to complete resection		

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	J. 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:
Tacrolimus	
INITIATION – organ transplant recipients Prerequisites (tick box where appropriate) O Prescribed by, or recommended by any specialist, or in accordance Hospital. and O For use in organ transplant recipients INITIATION – non-transplant indications* Prerequisites (tick boxes where appropriate)	with a protocol or guideline that has been endorsed by the Health NZ with a protocol or guideline that has been endorsed by the Health NZ
	nt because of unacceptable side effects or inadequate clinical response
Note: Indications marked with * are unapproved indications	

RS1879 - Etanercept

	200
Arthritis - rheumatoid - INITIATION	
Arthritis - rheumatoid - CONTINUATION	
Adult-onset Still's disease - INITIATION	
Adult-onset Still's disease - CONTINUATION	
Ankylosing spondylitis - INITIATION	
Ankylosing spondylitis - CONTINUATION	
Oligoarticular course juvenile idiopathic arthritis - INITIATION	
Oligoarticular course juvenile idiopathic arthritis - CONTINUATION	
Polyarticular course juvenile idiopathic arthritis - INITIATION	
Polyarticular course juvenile idiopathic arthritis - CONTINUATION	
Psoriatic arthritis - INITIATION	
Psoriatic arthritis - CONTINUATION	
Pyoderma gangrenosum - INITIATION	
Pyoderma gangrenosum - CONTINUATION	
Severe chronic plaque psoriasis - CONTINUATION	
Severe chronic plaque psoriasis, prior TNF use - INITIATION	
Severe chronic plaque psoriasis, treatment-naive - INITIATION	
Undifferentiated spondyloarthritis - INITIATION	
Undifferentiated spondyloarthritis - CONTINUATION	

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.

PRE	SCRI	BER		PATIENT:
Name:				Name:
Ward	:			NHI:
Etar	erce	ept		
Re-a	asses: requis	sment sites (Presci	requi tick b ibed	ticular course juvenile idiopathic arthritis red after 6 months oxes where appropriate) by, or recommended by a rheumatologist or named specialist, or in accordance with a protocol or guideline that has been endorsed th NZ Hospital.
		and	0	The patient has had an initial Special Authority approval for adalimumab for polyarticular course juvenile idiopathic arthritis (JIA)
		and	or	 O The patient has experienced intolerable side effects from adalimumab O The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for polyarticular course JIA
	or		_	
		and	Ο	To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance Patient has had polyarticular course JIA for 6 months duration or longer
			or	O At least 5 active joints and at least 3 joints with limited range of motion, pain or tenderness after a 3-month trial of methotrexate (at the maximum tolerated dose)
			or	O Moderate or high disease activity (cJADAS10 score of at least 2.5) after a 3-month trial of methotrexate (at the maximum tolerated dose)
				O Low disease activity (cJADAS10 score between 1.1 and 2.5) after a 6-month trial of methotrexate
Re-a	asses	sment	requi	olyarticular course juvenile idiopathic arthritis red after 6 months oxes where appropriate)
and				by, or recommended by a rheumatologist or named specialist, or in accordance with a protocol or guideline that has been endorsed th NZ Hospital.
	O Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxic intolerance and			
		or	0 0	Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baseline On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline
	1			

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.

PRES	CRIB	ER		PATIENT:
Name	:			Name:
Ward:				NHI:
Etan	erce	pt-a	conti	nued
Re-as	ssessi	ment	requ	rticular course juvenile idiopathic arthritis red after 6 months oxes where appropriate)
and				by, or recommended by a rheumatologist or named specialist, or in accordance with a protocol or guideline that has been endorsed in NZ Hospital.
		and	О	The patient has had an initial Special Authority approval for adalimumab for oligoarticular course juvenile idiopathic arthritis (JIA)
		unu	or	 O The patient has experienced intolerable side effects from adalimumab O The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for
	or			oligoarticular course JIA
		and and	0	To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance Patient has had oligoarticular course JIA for 6 months duration or longer
		una	or	O At least 2 active joints with limited range of motion, pain or tenderness after a 3-month trial of methotrexate (at the maximum tolerated dose)
			or	O Moderate or high disease activity (cJADAS10 score greater than 1.5) with poor prognostic features after a 3-month trial of methotrexate (at the maximum tolerated dose)
				O High disease activity (cJADAS10 score greater than 4) after a 6-month trial of methotrexate
Re-as	ssessi	ment	requ	igoarticular course juvenile idiopathic arthritis red after 6 months oxes where appropriate)
	Эр	Prescri	bed	by, or recommended by a rheumatologist or named specialist, or in accordance with a protocol or guideline that has been endorsed the NZ Hospital.

Subsidised as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance

Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baselinee

On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline

and

()

or

 \bigcirc

and

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.	

PRESCR	IBER		PATIENT:				
Name:			Name:				
Ward:	/ard: NHI:						
Etanero	cept	- cont	nued				
Re-asse	ssmer isites	nt requ (tick b cribed	tis - rheumatoid ired after 6 months ioxes where appropriate) by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ				
	ar	O d	The patient has had an initial Special Authority approval for adalimumab for rheumatoid arthritis				
		or	 O The patient has experienced intolerable side effects O The patient has received insufficient benefit to meet the renewal criteria for rheumatoid arthritis 				
or	ar ar ar ar		 Patient has had rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic citrullinated peptide (CCP) antibody positive) for six months duration or longer Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance Patient has tried and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated) Patient has tried and not responded to at least three months of methotrexate in combination with sulfasalazine and hydroxychloroquine sulphate at maximum tolerated doses (unless contraindicated) Patient has tried and not responded to at least three months of methotrexate in combination with the maximum tolerated dose of ciclosporin Patient has tried and not responded to at least three months of therapy at the maximum tolerated dose of leflunomide alone or in combination with methotrexate Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen joints 				
Re-asse	ssmer isites Pres	nt requ (tick b	Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip arthritis - rheumatoid ired after 2 years noxes where appropriate) by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health I.				
and	\cap	Trock					

and		0	Following 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	0	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:	
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Use this checklist to determine if a patient meets the restrictions for funding in the hospital setting	. For more details, ref	er to Section H of the Pharmac	ceutical
Schedule. For community funding, see the Special Authority Criteria.			

PRESC	RIBE	ER						PATIENT:
Name:								Name:
Ward: .	Ward: NHI:						NHI:	
Etaner	rcer	ot-co	ntin	ued				
INITIAT	FION	– ank	ylos	sing s	pondylitis			
			•		er 6 months here appropri	ate)		
						,		
		ospital.		y, or r	ecommendeo	by a meumatologist, or i	in accordar	nce with a protocol or guideline that has been endorsed by the Health NZ
and	(
		and () -	The p	atient has hac	I an initial Special Authori	ity approva	I for adalimumab for ankylosing spondylitis
				\bigcirc	The natient h	as experienced intolerable	e side effer	ets from adalimumah
			or	\frown				
					The patient has ankylosing sp		enefit from	adalimumab to meet the renewal criteria for adalimumab for
0	l				, , ,			
	"	C) ,	Pation	t has a confir	med diagnosis of ankylos	ing spondy	vitis present for more than six months
		and	、 、					
		and	J	Patier	it has low bac	k pain and stiffness that is	s relieved b	by exercise but not by rest
		C) (Patier	it has bilateral	sacroiliitis demonstrated	l by plain ra	adiographs, CT or MRI scan
		and) (Patier	it's ankylosino	spondylitis has not respo	onded adeo	quately to treatment with two or more non-steroidal anti-inflammatory
			C	drugs	(NSAIDs), in	combination with anti-ulce r ankylosing spondylitis	er therapy i	if indicated, while patient was undergoing at least 3 months of a regular
		and			se regimento			
								e in the sagittal and the frontal planes as determined by the following
								SMI) measures: a modified Schober's test of less than or equal to s than or equal to 10 cm (mean of left and right)
		'	or	Ο	Patient has lir	nitation of chest expansic	on by at lea	st 2.5 cm below the average normal values corrected for age and
					gender (see N		·	
		and) ,	Dath /	Naludacian Ca	andulitia Diagona Activity	Index (DA)	
				Sath P	Ankylosing Sp	ondyinis Disease Activity	Index (BAS	SDAI) of at least 6 on a 0-10 scale
						mined at the completion of old at the time of starting		onth exercise trial, but prior to ceasing NSAID treatment. The BASDAI
					nsion correcte	d for age and gender:	acament.	
			ge		Male	Female		
			3-24		7.0 cm	5.5 cm		
			5-34		7.5 cm	5.5 cm		
			5-44		6.5 cm	4.5 cm		
			5-54		6.0 cm	5.0 cm		
		55	5-64		5.5 cm	4.0 cm		

65-74

75+

4.0 cm

3.0 cm

4.0 cm

2.5 cm

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.

PRESC	RIBE	R	PATIENT:	
Name:			Name:	
Ward: .				
Etaner	cep	t-c	tinued	
Re-ass Prereq	essm uisite Pre	ent re es (tio escrit spita	ankylosing spondylitis juired after 6 months boxes where appropriate) d by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health owing 12 weeks' initial treatment and for subsequent renewals, treatment has resulted in an improvement in BASDAI of 4 or m hts from pre-treatment baseline on a 10 point scale, or an improvement in BASDAI of 50%, whichever is less riscian considers that the patient has benefited from treatment and that continued treatment is appropriate	
a	nd) _E	nercept to be administered at doses no greater than 50 mg every 7 days	
Re-ass	essm uisite Pre	ent ro es (tio	iatic arthritis juired after 6 months boxes where appropriate) d by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health	n NZ
		(and	 The patient has had an initial Special Authority approval for adalimumab or secukinumab for psoriatic arthritis O The patient has experienced intolerable side effects from adalimumab or secukinumab r O The patient has received insufficient benefit from adalimumab or secukinumab to meet the renewal criteria for adalimumab or secukinumab for psoriatic arthritis 	
o	ŧ	and and and	 Patient has had severe active psoriatic arthritis for six months duration or longer Patient has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a maximum tolerated dose Patient has tried and not responded to at least three months of sulfasalazine at a dose of at least 2 g per day or leflunomide a dose of up to 20 mg daily (or maximum tolerated doses) O Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen, tender joints 	at
	ŧ	and	 Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist elbow, knee, ankle, and either shoulder or hip Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application Patient has an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour 	
			C ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per d and has done so for more than three months	ay

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.

PRES	CRIE	BER			PATIENT:	
Name	ame: Name:					
Ward:					NHI:	
Etan	erce	ept -	- conti	nued		
Re-a	ssess	smen	t requ	soriatic arthritis ired after 6 months oxes where appropriate)		
(and		Preso Hosp		by, or recommended by a rheumatologist, or in accordance	ce with a protocol or guideline that has been endorsed by the Health NZ	
	¢	or	0 0	clinically significant response to treatment in the opinion	rovement in active joint count from baseline and a clinically significant	
	and	0	Etane	ercept to be administered at doses no greater than 50 mg	every 7 days	
Re-a	ssess equis	ites	t requ (tick b	e chronic plaque psoriasis, prior TNF use ired after 4 months oxes where appropriate)	e with a protocol or guideline that has been endorsed by the Health NZ	
and		Hosp				
	and	0	The p	patient has had an initial Special Authority approval for ad	alimumab for severe chronic plaque psoriasis	
			0	The patient has experienced intolerable side effects from	nadalimumab	
		or	Ο	The patient has received insufficient benefit from adalimit plaque psoriasis	umab to meet the renewal criteria for adalimumab for severe chronic	
	and	0	Patie	nt must be reassessed for continuation after 3 doses		

I confirm that the above details are correct:

Schedule. For community funding, see the Special Authority Criteria.	
Use this checklist to determine if a patient meets the restrictions for funding in the hospital setting. I	For more details, refer to Section H of the Pharmaceutical

SCRIBER	PATIENT:
e:	Name:
I:	NHI:
nercept -	continued
-	evere chronic plaque psoriasis, treatment-naive
assessment	required after 4 months
equisites (tick boxes where appropriate)
O Presci Hospit	ribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal.
	O Patient has "whole body" severe chronic plaque psoriasis with a Psoriasis Area and Severity Index (PASI) score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis
or	O Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis
	Patient has tried, but had an inadequate response (see Note) to, or has experienced intolerable side effects from, at least three of the following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, ciclosporin, or acitretin
0	A PASI assessment or Dermatology Quality of Life Index (DLQI) assessment has been completed for at least the most recent prior treatment course (but preferably all prior treatment courses), preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course
e: "Inadequa e still on trea d or foot, at cted is 30%	The most recent PASI or DLQI assessment is no more than 1 month old at the time of initiation ate response" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 10, as assessed preferably atment but no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the fac least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very severe, and the skin area or more of the face, palm of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month follow most recent prior treatment
e: "Inadequa e still on trea d or foot, at cted is 30% sation of the VTINUATIO assessment requisites (ate response" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 10, as assessed preferably atment but no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the fac least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very severe, and the skin area or more of the face, palm of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month follow most recent prior treatment.
e: "Inadequa e still on trea d or foot, at cted is 30% sation of the VTINUATIO assessment requisites (ate response" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 10, as assessed preferably atment but no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the face least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very severe, and the skin area or more of the face, palm of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month follow most recent prior treatment. N – severe chronic plaque psoriasis required after 6 months tick boxes where appropriate) ribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
C "Inadequa e still on trea d or foot, at cted is 30% sation of the VTINUATIO assessment requisites (O Presci	ate response" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 10, as assessed preferably atment but no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the face least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very severe, and the skin area or more of the face, palm of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month follow most recent prior treatment. N – severe chronic plaque psoriasis required after 6 months tick boxes where appropriate) ribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
C "Inadequa e still on trea d or foot, at cted is 30% sation of the VTINUATIO assessment requisites (O Presci	ate response" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 10, as assessed preferably atment but no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the face least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very severe, and the skin area or more of the face, palm of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month follow most recent prior treatment. N – severe chronic plaque psoriasis required after 6 months tick boxes where appropriate) ribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
"Inadequation of the set still on treated or foot, at cited is 30% action of the set of the se	ate response" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 10, as assessed preferably atment but no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the far or more of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very severe, and the skin area or more of the face, palm of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment. N – severe chronic plaque psoriasis required after 6 months tick boxes where appropriate) ribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal. P – Attent had "whole body" severe chronic plaque psoriasis at the start of treatment and
C "Inadequa e still on trea d or foot, at cted is 30% sation of the VTINUATIO assessment requisites (O Presci	ate response" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 10, as assessed preferably atment but no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the far least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very severe, and the skin area or more of the face, palm of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month follow most recent prior treatment. N - severe chronic plaque psoriasis required after 6 months tick boxes where appropriate) ribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal. O Patient had "whole body" severe chronic plaque psoriasis at the start of treatment and O Following each prior etanercept treatment course the patient has a PASI score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-etanercept treatment baseline value Following each prior etanercept treatment course the patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, when compared with the pre-treatment baseline value
"Inadequation of the still on treation of the still on treation of the still on treation of the station of	ate response" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 10, as assessed preferably atment but no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the face or more of the face, palm of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month follow most recent prior treatment. N – severe chronic plaque psoriasis required after 6 months tick boxes where appropriate) ribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal. Patient had "whole body" severe chronic plaque psoriasis at the start of treatment or or or is sustained at this level, when compared with the pre-etanercept treatment baseline value or or or be patient has a Dermatology Quality of Life Index (DLQI)
e: "Inadequa e still on tread d or foot, at cted is 30% sation of the NTINUATIO assessment requisites (O Presci Hospit	ate response" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 10, as assessed preferably atment but no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the fa least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very severe, and the skin area or more of the face, palm of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month follow most recent prior treatment. N - severe chronic plaque psoriasis required after 6 months tick boxes where appropriate) ribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal. N - severe chronic plaque psoriasis required after 6 months tick boxes where appropriate) ribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal. N - severe chronic plaque psoriasis at the start of treatment and o Following each prior etanercept treatment course the patient has a PASI score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-etanercept treatment baseline value o Following each prior etanercept treatment course the patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, when compared with the pre-treatment baseline value

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	PATIENT:
Name:	Name:
Ward:	
Etanercept - continued	
INITIATION – pyoderma gangrene Prerequisites (tick boxes where ap	
Prescribed by, or recomm Hospital.	nended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
O Patient has pyoderr	na gangrenosum*
O Patient has receive	d three months of conventional therapy including a minimum of three pharmaceuticals (e.g. prednisone, ciclosporin, thotrexate) and not received an adequate response
O A maximum of 8 do	
Note: Indications marked with * are	a unapproved indications.
CONTINUATION – pyoderma gan Prerequisites (tick boxes where ap	
O Prescribed by, or recomm Hospital.	nended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
	clinical improvement
Patient continues to	o require treatment
A maximum of 8 do	uses
INITIATION – adult-onset Still's d Re-assessment required after 6 mc	
Prerequisites (tick boxes where ap	opropriate)
O Prescribed by, or recomm Hospital.	nended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
O The part	tient has had an initial Special Authority approval for etanercept for adult-onset Still's disease (AOSD)
	tient has been started on tocilizumab for AOSD in a Health NZ Hospital
and O The pa	tient has experienced intolerable side effects from etanercept and/or tocilizumab
	tient has received insufficient benefit from at least a three-month trial of adalimumab and/or tocilizumab such that onot meet the renewal criteria for AOSD
or	
O Patient diagn	osed with AOSD according to the Yamaguchi criteria (J Rheumatol 1992;19:424-430)
O Patient has tr	ied and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, non-steroidal tory drugs (NSAIDs) and methotrexate
	ersistent symptoms of disabling poorly controlled and active disease

			determine if a patient meets the restrictions for funding in the hospital setting . For more details, refer to Section H of the Pharmaceut nunity funding, see the Special Authority Criteria.
PRES	SCRIB	ER	PATIENT:
Name	ə:		Name:
Ward	:		NHI:
Etan	erce	pt ·	tinued
Re-a	assess requis O F H	men ites Presc losp	adult-onset Still's disease uired after 6 months box where appropriate) d by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ nt has a sustained improvement in inflammatory markers and functional status
Re-a	assess requis	men ites	Iferentiated spondyloarthritis uired after 6 months boxes where appropriate) d by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
Note	and (and (and (and) (and	or or	ent has undifferentiated peripheral spondyloarthritis* with active peripheral joint arthritis in at least four joints from the following: t, elbow, knee, ankle, and either shoulder or hip ent has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a timum tolerated dose ent has tried and not responded to at least three months of sulfasalazine at a dose of at least 2 g per day (or maximum tolerated ent has tried and not responded to at least three months of sulfasalazine at a dose of at least 2 g per day (or maximum tolerated ent has tried and not responded to at least three months of leflunomide at a dose of up to 20 mg daily (or maximum tolerated dose) ent has tried and not responded to at least three months of leflunomide at a dose of up to 20 mg daily (or maximum tolerated dose) Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application Patient has an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour measured no more than one month prior to the date of this application ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months tarked with * are unapproved indications.
Re-a	equis	men	undifferentiated spondyloarthritis uired after 6 months boxes where appropriate) Applicant is a rheumatologist Applicant is a Practitioner and confirms that a rheumatologist has provided a letter, email or fax recommending that the patient continues with etanercept treatment
	and	or	Following 3 to 4 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

The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior etanercept treatment in the opinion of the treating physician

O Etanercept to be administered at doses no greater than 50 mg dose every 7 days

()

and

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	PATIENT:
Name:	Name:
Ward:	NHI:

Bevacizumab

INITIATION – Recurrent Respiratory Papillomatosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by an otolaryngologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and () Maximum of 6 doses and The patient has recurrent respiratory papillomatosis and () The treatment is for intra-lesional administration **CONTINUATION – Recurrent Respiratory Papillomatosis** Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) () Prescribed by, or recommended by an otolaryngologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and () Maximum of 6 doses and The treatment is for intra-lesional administration and ()There has been a reduction in surgical treatments or disease regrowth as a result of treatment **INITIATION** – ocular conditions Prerequisites (tick boxes where appropriate)

or

Ocular neovascularisation

Exudative ocular angiopathy

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:
Ranibizumab	
INITIATION – Wet Age Related Macular Degeneration	

			aired after 3 months boxes where appropriate)
and			by, or recommended by an ophthalmologist or nurse practitioner, or in accordance with a protocol or guideline that has been by the Health NZ Hospital.
		or	O Wet age-related macular degeneration (wet AMD)
		or	O Polypoidal choroidal vasculopathy
			O Choroidal neovascular membrane from causes other than wet AMD
	ar	nd	
		or	O The patient has developed severe endophthalmitis or severe posterior uveitis following treatment with bevacizumab
			O There is worsening of vision or failure of retina to dry despite three intraocular injections of bevacizumab four weeks apart
	ar	Ο	There is no structural damage to the central fovea of the treated eye
	a	Ö	Patient has not previously been treated with aflibercept for longer than 3 months
	or O	Patie	ent has current approval to use aflibercept for treatment of wAMD and was found to be intolerant to aflibercept within 3 months
\sum			
CONT		<u> 1</u>	Net Age Related Macular Degeneration

CONTINUATION – Wet Age Related Macular Degeneration

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

and

and

O Prescribed by, or recommended by an ophthalmologist or nurse practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

O Documented benefit must be demonstrated to continue

Patient's vision is 6/36 or better on the Snellen visual acuity score

There is no structural damage to the central fovea of the treated eye

Signed: Date:

RS1941 - Infliximab

(
Crohn's disease (adults) - INITIATION	316
Crohn's disease (adults) - CONTINUATION	
Crohn's disease (children) - INITIATION	316
Crohn's disease (children) - CONTINUATION	
Graft vs host disease - INITIATION	
Inflammatory bowel arthritis (axial) - INITIATION	
Inflammatory bowel arthritis (axial) - CONTINUATION	
Inflammatory bowel arthritis (peripheral) - INITIATION	323
Inflammatory bowel arthritis (peripheral) - CONTINUATION	323
Pulmonary sarcoidosis - INITIATION	315
Acute fulminant ulcerative colitis - INITIATION	
Ankylosing spondylitis - INITIATION	
Ankylosing spondylitis - CONTINUATION	
Chronic ocular inflammation - INITIATION	
Chronic ocular inflammation - CONTINUATION	
Fistulising Crohn's disease - INITIATION	
Fistulising Crohn's disease - CONTINUATION	
Fulminant ulcerative colitis - CONTINUATION	
Neurosarcoidosis - INITIATION	
Neurosarcoidosis - CONTINUATION	
Plaque psoriasis - INITIATION	
Plaque psoriasis - CONTINUATION	
Psoriatic arthritis - INITIATION	
Psoriatic arthritis - CONTINUATION	
Pyoderma gangrenosum - INITIATION	
Pyoderma gangrenosum - CONTINUATION	
Rheumatoid arthritis - INITIATION	
Rheumatoid arthritis - CONTINUATION	312
Severe Behcet's disease - INITIATION	321
Severe Behcet's disease - CONTINUATION	321
Severe ocular inflammation - INITIATION	
Severe ocular inflammation - CONTINUATION	
Ulcerative colitis - INITIATION	
Ulcerative colitis - CONTINUATION	319

Use this checklist to determine if a patient meets the restrictions for funding in the h	ospital 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:
Infliximab	
INITIATION – Graft vs host disease Prerequisites (tick box where appropriate) O Patient has steroid-refractory acute graft vs. host disease of the graft vs.	ut
INITIATION – rheumatoid arthritis Re-assessment required after 4 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a rheumatologist, or in accordation Hospital.	ance with a protocol or guideline that has been endorsed by the Health NZ
or	adalimumab and/or etanercept for rheumatoid arthritis om a reasonable trial of adalimumab and/or etanercept d/or etanercept, the patient did not meet the renewal criteria for
adalimumab and/or etanercept and Treatment is to be used as an adjunct to methotrexate therap intolerance CONTINUATION – rheumatoid arthritis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	py or monotherapy where use of methotrexate is limited by toxicity or ance with a protocol or guideline that has been endorsed by the Health NZ
intolerance	py or monotherapy where use of methotrexate is limited by toxicity or
clinically significant response to treatment in the opinio	has at least a 50% decrease in active joint count from baseline and a on of the physician nprovement in active joint count from baseline and a clinically significant
and O Infliximab to be administered at doses no greater than 3 mg/	/kg every 8 weeks
INITIATION – ankylosing spondylitis Re-assessment required after 3 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a rheumatologist, or in accordation Hospital. and O The patient has had an initial Special Authority approval for a and	ance with a protocol or guideline that has been endorsed by the Health NZ adalimumab and/or etanercept for ankylosing spondylitis
	om a reasonable trial of adalimumab and/or etanercept

O Following 12 weeks of adalimumab and/or etanercept treatment, the patient did not meet the renewal criteria for adalimumab and/or etanercept for ankylosing spondylitis

I confirm that the above details are correct:

Signed:	Date:
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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.

PRES	CRIBER	ER PATIENT:	
Name	:	Name:	
Ward:		NHI:	
Inflix	imab -) - continued	
		ATION – ankylosing spondylitis ment required after 6 months	
Prere	equisites	tes (tick boxes where appropriate)	
(and		rescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Herologistal.	alth NZ
	and	Following 12 weeks of infliximab treatment, BASDAI has improved by 4 or more points from pre-infliximab baseline on a 10 point or by 50%, whichever is less	nt scale,
	0	O Physician considers that the patient has benefited from treatment and that continued treatment is appropriate	
	and	O Infliximab to be administered at doses no greater than 5 mg/kg every 6-8 weeks	
Re-a	ssessmei equisites O Pres	 I – psoriatic arthritis ment required after 4 months tes (tick boxes where appropriate) rescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Herologistal. 	alth NZ
and	and	O The patient has had an initial Special Authority approval for adalimumab and/or etanercept and/or secukinumab for psoriatic and O The patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept and/or seculation of the patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept and/or seculation of the patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept and/or seculation of the patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept and/or seculation of the patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept and/or seculation of the patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept and/or seculation of the patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept and/or seculation of the patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept and/or seculation of the patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept and/or seculation of the patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept and/or seculation of the patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept and/or seculation of the patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept and/or seculation of the patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept and/or seculation of the patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept and/or seculation of the patient has experienced intolerable side effects from a reasonable trial of adalimumab	
	or	or O Following 3-4 months' initial treatment with adalimumab and/or etanercept and/or secukinumab, the patient did not meet renewal criteria for adalimumab and/or etanercept and/or secukinumab for psoriatic arthritis.	
Re-a	ssessmei equisites O Pres	ATION – psoriatic arthritis ment required after 6 months tes (tick boxes where appropriate) rescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Her lospital.	alth NZ
	or	 Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and clinically significant response to treatment in the opinion of the physician The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior infliximab treatment in the opinion of the treating physician 	
	and	O Infliximab to be administered at doses no greater than 5 mg/kg every 8 weeks	

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:
Infliximab antiqued	

Infliximab - continued

			vere ocular inflammation required after 4 months
			ick boxes where appropriate)
ſ			
		(and	O The patient has had an initial Special Authority approval for adalimumab for severe ocular inflammation
			O The patient has experienced intolerable side effects from adalimumab
			O The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for severe ocular inflammation
	or		
		(and	O Patient has severe, vision-threatening ocular inflammation requiring rapid control
			O Treatment with high-dose steroids (intravenous methylprednisolone) followed by high dose oral steroids has proven ineffective at controlling symptoms
			O Patient developed new inflammatory symptoms while receiving high dose steroids
			or O Patient is aged under 8 years and treatment with high dose oral steroids and other immunosuppressants has proven ineffective at controlling symptoms
Re-as	sess	ment i	I – severe ocular inflammation required after 12 months
Prere	quis	ites (ti	ick boxes where appropriate)
	(тС	The patient has had a good clinical response following 3 initial doses
	or (Ν	Following each 12-month treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < $\frac{1}{2}$ + anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of Iveitic cystoid macular oedema)
	or (ЭF	Following each 12-month treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to to 10 to

Note: A trial withdrawal should be considered after every 24 months of stability, unless the patient is deemed to have extremely high risk of irreversible vision loss if infliximab is withdrawn.

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:
Infliximab - continued	
INITIATION – chronic ocular inflammation	

	(and	С	The patient has had an initial Special Authority approval for adalimumab for chronic ocular inflammation
		or	O The patient has experienced intolerable side effects from adalimumab
			O The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for chronic ocular inflammation
or			
	and	С	Patient has severe uveitis uncontrolled with treatment of steroids and other immunosuppressants with a severe risk of vision loss
		or	O Patient is 18 years or older and treatment with at least two other immunomodulatory agents has proven ineffective
			O Patient is under 18 years and treatment with methotrexate has proven ineffective or is not tolerated at therapeutic dose
		or	• O Patient is under 8 years and treatment with steroids or methotrexate has proven ineffective or is not tolerated at a therapeutic dose; or disease requires control to prevent irreversible vision loss prior to achieving a therapeutic dose of methotrexate
		requ	chronic ocular inflammation uired after 12 months poxes where appropriate)

Following each 12-month treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema)

Following each 12-month treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old

Note: A trial withdrawal should be considered after every 24 months of stability, unless the patient is deemed to have extremely high risk of irreversible vision loss if infliximab is withdrawn.

INITIATION – Pulmonary sarcoidosis Prerequisites (tick boxes where appropriate)

or

and ()

()

Patient has life-threatening pulmonary sarcoidosis that is refractory to other treatments

Treatment is to be prescribed by, or has been recommended by, a physician with expertise in the treatment of pulmonary sarcoidosis

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.

PRES	CRIB	ER	PATIENT:	
Name	:		Name:	
Ward:			NHI:	
Inflix	ima	b - (ntinued	
Re-a	ssess equis	ites Presc	bhn's disease (adults) equired after 6 months ck boxes where appropriate) bed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health	
and	г (pital. atient has active Crohn's disease)
	and	\subset		
		or	Patient has a CDAI score of greater than or equal to 300, or HBI score of greater than or equal to 10	
		or	O Patient has extensive small intestine disease affecting more than 50 cm of the small intestine	
			O Patient has evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel resection	
		or	O Patient has an ileostomy or colostomy, and has intestinal inflammation	
	and (0	atient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulator nd corticosteroids	rs
and	<u>م</u>		 D CDAI score has reduced by 100 points from the CDAI score, or HBI score has reduced by 3 points, from when the patient was initiated on infliximab D CDAI score is 150 or less, or HBI is 4 or less D The patient has demonstrated an adequate response to treatment but CDAI score and/or HBI score cannot be assessed 	
	and	0	Ifliximab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for to 3 doses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen eeks after completing the last re-induction cycle	
Re-a	ssess	men	bhn's disease (children) equired after 6 months ck boxes where appropriate)	
and			bed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health pital.	
	์ and	0	aediatric patient has active Crohn's disease	
		or	Patient has a PCDAI score of greater than or equal to 30	
			O Patient has extensive small intestine disease	
	and (О	atient has tried but experienced an inadequate response to, or intolerable side effects from, prior therapy with immunomodulators nd corticosteroids	

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				PATIENT:		
Name	e:			Name:		
Ward:	:			NHI:		
Inflix	kimab	- contir	nued			
Re-a	ssessmo equisite	ent requ s (tick l	Crohn's disease (children) uired after 2 years boxes where appropriate)			
and		Hospita		cordance with a protocol or guideline that has been endorsed by the Health		
	C	O Pr	PCDAI score has reduced by 10 points from the PCDAI	score when the patient was initiated on infliximab		
		or O	PCDAI score is 15 or less			
		O	The patient has demonstrated an adequate response to	treatment but PCDAI score cannot be assessed		
	and	up to		weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for nent for re-induction. Another re-induction may be considered sixteen		
and		spital.	ent has confirmed Crohn's disease	dance with a protocol or guideline that has been endorsed by the Health NZ		
	c	r O	Patient has one or more complex externally draining enter Patient has one or more rectovaginal fistula(e)	erocutaneous fistula(e)		
	c	r O	Patient has complete peri-anal fistula			
Re-a	ssessm	ent requ	iistulising Crohn's disease uired after 2 years boxes where appropriate)			
O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the H NZ Hospital.						
	C		The number of open draining fistulae have decreased from There has been a marked reduction in drainage of all fis a reduction in the Fistula Assessment score), together w	tula(e) from baseline (in the case of adult patients, as demonstrated by		
	and	up to		veeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for nent for re-induction. Another re-induction may be considered sixteen		

	st to determine if a patient meets the restrictions for funding in t community funding, see the Special Authority Criteria.	he hospital setting . For more details, refer to Section H of the Pharmaceutical					
PRESCRIBER		PATIENT:					
Name:		Name:					
Ward:		NHI:					
Infliximab -	continued						
Re-assessmer		dance with a protocol or guideline that has been endorsed by the Health NZ					
and	O Patient has acute, fulminant ulcerative colitis						
Re-assessmer	DN – fulminant ulcerative colitis nt required after 2 years (tick boxes where appropriate)						
	cribed by, or recommended by any relevant practitioner, or in a lospital.	ccordance with a protocol or guideline that has been endorsed by the Health					
and	reassessed every 6 months Infliximab to be administered at doses up to 5 mg/kg every 8	ximab should be used in combination with immunomodulators and weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for ment for re-induction. Another re-induction may be considered sixteen					
Re-assessmer	ulcerative colitis nt required after 6 months (tick boxes where appropriate)						
	cribed by, or recommended by any relevant practitioner, or in a lospital.	ccordance with a protocol or guideline that has been endorsed by the Health					
and	Patient has active ulcerative colitis O Patients SCCAI is greater than or equal to 4 O Patients PUCAI score is greater than or equal to 20						
and	Patient has experienced an inadequate response to, or intoler systemic corticosteroids	rable side effects from, prior therapy with immunomodulators and					

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.

PRESC	RIBER		PATIENT:			
Name:			Name:			
Ward:			NHI:			
Inflixir	nab -	contin	ued			
Re-ass Prereq	essmei j uisites) _{Pres}	nt requ (tick b cribed lospita	Ilcerative colitis irred after 2 years poxes where appropriate) by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health al. The SCCAI score has reduced by 2 points or more from the SCCAI score when the patient was initiated on infliximab The PUCAI score has reduced by 30 points or more from the PUCAI score when the patient was initiated on infliximab			
	0	up to	imab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for 3 doses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen as after completing the last re-induction cycle			
Re-ass	essmei j uisites	nt requ (tick b cribed	e psoriasis irred after 3 doses boxes where appropriate) by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ			
	ar	O	Patient has had an initial Special Authority approval for adalimumab, etanercept or secukinumab for severe chronic plaque psoriasis			
		or	 Patient has experienced intolerable side effects from adalimumab, etanercept or secukinumab Patient has received insufficient benefit from adalimumab, etanercept or secukinumab to meet the renewal criteria for adalimumab, etanercept or secukinumab for severe chronic plaque psoriasis 			
c	or _					
		or	 Patient has "whole body" severe chronic plaque psoriasis with a Psoriasis Area and Severity Index (PASI) score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis 			
	ar ar ar	O bh O	Patient has tried, but had an inadequate response (see Note) to, or has experienced intolerable side effects from, at least three of the following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, cyclosporin, or acitretin A PASI assessment has been completed for at least the most recent prior treatment course (but preferably all prior treatment courses), preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course The most recent PASI assessment is no more than 1 month old at the time of initiation			
while s hand o affecte	Note: "Inadequate response" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 10, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the face, hand or foot, at least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very severe, and the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment but no longer than 1 month following cessation of the most recent prior treatment but no longer than 1 month following cessation of the most recent prior treatment.					

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:			
Infliximab - continued				
CONTINUATION – plaque psoriasis Re-assessment required after 3 doses Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a dermatologist, or in accordance Hospital.	e with a protocol or guideline that has been endorsed by the Health NZ			
or	he patient has a PASI score which is reduced by 75% or more, or is			
or O Following each prior infliximab treatment co	purse the patient has a reduction in the PASI symptom subscores , to slight or better, or sustained at this level, as compared to the purse the patient has a reduction of 75% or more in the skin area ared to the pre-infliximab treatment baseline value			
INITIATION – neurosarcoidosis Re-assessment required after 18 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a neurologist, or in accordance Hospital. and	with a protocol or guideline that has been endorsed by the Health NZ			
 Biopsy consistent with diagnosis of neurosarcoidosis and Patient has CNS involvement and Patient has steroid-refractory disease and 				
or O IV cyclophosphamide has been tried O Treatment with IV cyclophosphamide is clinically inappr	opriate			

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.

PRES	CRI	RFF	2			PATIENT:
						INI II.
			- conti			
Re-a	sses equi	sme sites Pres Hos	ent req s (tick scribed pital.	thdrav A w The	osarcoidosis after 18 months s where appropriate) or recommended by a neurologist, or in accordar awal period has been tried and the patient has related withdrawal period has been considered but would ere has been a marked reduction in prednisone of There has been an improvement in MRI appe Marked improvement in other symptomology	not be clinically appropriate
Re-a	sses	site:	ent req s (tick	uired boxes	ehcet's disease after 4 months is where appropriate) ent has severe Behcet's disease which is significa	antly impacting the patient's quality of life (see Notes)
	an	0	0 ' 0	trea The	atment(s) appropriate for the particular symptom	gic and/or mucocutaneous symptoms and has not responded adequately to
	and	J O	The	patie	ent is experiencing significant loss of quality of life	
Note	:					
	a) Behcet's disease diagnosed according to the International Study Group for Behcet's Disease. Lancet 1990;335(8697):1078-80. Quality of life measured using an appropriate quality of life scale such as that published in Gilworth et al J Rheumatol. 2004;31:931-7.					
íir	b) Treatments appropriate for the particular symptoms are those that are considered standard conventional treatments for these symptoms, for example intravenous/oral steroids and other immunosuppressants for ocular symptoms; azathioprine, steroids, thalidomide, interferon alpha and ciclosporin for mucocutaneous symptoms; and colchicine, steroids and methotrexate for rheumatological symptoms.					
Re-a	CONTINUATION – severe Behcet's disease Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)					
	200	O Patient has had a good clinical response to initial treatment with measurably improved quality of life				

O Infliximab to be administered at doses no greater than 5 mg/kg every 8 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	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Infliximab - continued				
Hospital. and O Patient has pyoderma gangrenosum* and O Patient has received three months of conventional therapy inc azathioprine, or methotrexate) and not received an adequate r and O A maximum of 8 doses Note: Indications marked with * are unapproved indications.	e with a protocol or guideline that has been endorsed by the Health NZ			
CONTINUATION – pyoderma gangrenosum Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a dermatologist, or in accordance Hospital. and O Patient has shown clinical improvement and O Patient continues to require treatment and O A maximum of 8 doses	e with a protocol or guideline that has been endorsed by the Health NZ			
INITIATION - Inflammatory bowel arthritis (axial) Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Patient has a diagnosis of active ulcerative colitis or active Crohn's disease and O Patient has had axial inflammatory pain for six months or more and O Patient is unable to take NSAIDs and O Patient has unequivocal sacroillitis demonstrated by radiological imaging or MRI and O Patient has not experienced an adequate response to prior treatment consisting of at least 3 months of an exercise regime supervised by a physiotherapist and O Patient has a BASDAI of at least 6 on a 0-10 scale completed after the 3 month exercise trial, but prior to ceasing any previous pharmacological treatment				
CONTINUATION – Inflammatory bowel arthritis (axial) Re-assessment required after 2 years Prerequisites (tick box where appropriate) O Where treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10-point scale, or an improvement in BASDAI of 50%, whichever is less				

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:		
Inflix	ima	ıb - d	continued			
Re-a	ssess	smen	nflammatory bowel arthritis (peripheral) t required after 6 months (tick boxes where appropriate)			
	and	Ο	Patient has a diagnosis of active ulcerative colitis or active Cro	hn's disease		
	and	0	Patient has active arthritis in at least four joints from the follow sternoclavicular	ing: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder,		
	_	0	Patient has tried and not experienced a response to at least three months of methotrexate or azathioprine at a maximum tolerated dose (unless contraindicated)			
	and	0	Patient has tried and not experienced a response to at least th contraindicated)	ree months of sulfasalazine at a maximum tolerated dose (unless		
	and	or	O Patient has a CRP level greater than 15 mg/L measured	d no more than one month prior to the date of this application		
			O Patient has an ESR greater than 25 mm per hour measurements of the second	ured no more than one month prior to the date of this application		
		or	O ESR and CRP not measured as patient is currently rece has done so for more than three months	iving prednisone therapy at a dose of greater than 5 mg per day and		
Re-a	ssess	smen	N – Inflammatory bowel arthritis (peripheral) t required after 2 years (tick boxes where appropriate)			
		0	Following initial treatment, patient has experienced at least a 5 significant response to treatment in the opinion of the physician	0% decrease in active joint count from baseline and a clinically n		
	or	0	Patient has experienced at least a continuing 30% improvement physician	nt in active joint count from baseline in the opinion of the treating		
\subseteq						

RS2025 - Tocilizumab

Rheumatoid Arthritis - INITIATION	327
Rheumatoid Arthritis - CONTINUATION	329
Rheumatoid Arthritis (patients previously treated with adalimumab or etanercept) - INITIATION	326
Adult-onset Still's disease - INITIATION	328
Adult-onset Still's disease - CONTINUATION	330
Cytokine release syndrome - INITIATION	
Idiopathic multicentric Castleman's disease - INITIATION	
Idiopathic multicentric Castleman's disease - CONTINUATION	330
Moderate to severe COVID-19 - INITIATION	
Polyarticular juvenile idiopathic arthritis - INITIATION	328
Polyarticular juvenile idiopathic arthritis - CONTINUATION	
Previous use - INITIATION	
Systemic juvenile idiopathic arthritis - INITIATION	
Systemic juvenile idiopathic arthritis - CONTINUATION	329

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:	Name:	
Ward:	NHI:	

Tocilizumab

INITIATION – cytokine release syndrome Re-assessment required after 3 doses							
Prer	Prerequisites (tick boxes where appropriate)						
		and	treatment of acute lymphoblastic leukaemia	L1731 trial drome associated with the administration of blinatumomab for the mg/kg IV for a maximum of 3 doses (if less than 30kg, maximum			
	or	and	therapy for the treatment of relapsed or refractory B-cell non	ociated Neurotoxicity Syndrome (ICANS) following CAR T-Cell			
Re-a	assess	ment	evious use equired after 6 months				
Prer	equis	ites (1	ck boxes where appropriate)				
and	O F	Prescr NZ Ho	bed by, or recommended by any relevant practitioner, or in accord pital.	ance with a protocol or guideline that has been endorsed by the Health			
	and	C	atient was being treated with tocilizumab prior to 1 February 201	9			
			O Rheumatoid arthritis				
	or O Systemic juvenile idiopathic arthritis or O Adult-onset Still's disease						
		or	O Polyarticular juvenile idiopathic arthritis				
		or	O Idiopathic multicentric Castleman's disease				

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.						
PRES	CRIB	ER			PATIENT:	
Name	Name:					
Ward:					NHI:	
Tocil	izun	nab	- cor	ntinue		
					rthritis (patients previously treated with adalimumab or etanercept)	
					ere appropriate)	
and			col or	guid	commended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a e that has been endorsed by the Health NZ Hospital.	
and O The patient has experienced intolerable side effects from adalimumab and/or etanercept or O The patient has received insufficient benefit from at least a three-month trial of adalimumab and/or etanercept such that						
	and	\subseteq				
	O 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				ne patient has been started on rituximab for rheumatoid arthritis in a Health NZ Hospital		
	O The patient has experienced intolerable side effects from rituximab					
					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	

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.

PRES	CRIB	ER		PATIENT:		
Name	lame:					
Ward	/ard:			NHI:		
Toci	izum	nab	- cor	ntinued		
Re-a	ssessi	men	t requ	natoid Arthritis ired after 6 months		
Prer	equisi	tes	(tick b	poxes where appropriate)		
(and				by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.		
	(С		nt has had severe and active erosive rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic linated peptide (CCP) antibody positive) for six months duration or longer		
	and (and	C	Tocili	zumab is to be used as monotherapy		
		or	Ο	Treatment with methotrexate is contraindicated		
		U	Ο	Patient has tried and did not tolerate oral and/or parenteral methotrexate		
	and					
			\bigcirc	Patient has tried and not responded to at least three months therapy at the maximum tolerated dose of ciclosporin alone or in combination with another agent		
		or	0	Patient has tried and not responded to at least three months therapy at the maximum tolerated dose of leflunomide alone or in combination with another agent		
	and					
		or	0	Patient has persistent symptoms of poorly controlled and active disease in at least 20 active, swollen, tender joints		
			0	Patient has persistent symptoms of poorly controlled and active disease in at least four active joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip		
	and	\subseteq	_			
		or	0	Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application		
			0	C-reactive protein levels not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months		
Re-a	ssessi	men	t requ	nic juvenile idiopathic arthritis ired after 6 months		
Prer	~			poxes where appropriate)		
(and				by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.		
	(and	С	Patie	nt diagnosed with systemic juvenile idiopathic arthritis		
	O Patient has tried and not responded to a reasonable trial of all of the following, either alone or in combination: oral or parenteral methotrexate; non-steroidal anti-inflammatory drugs (NSAIDs); and systemic corticosteroids					

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.

PRE	SCRIE	BER		PATIENT:
Nam	e:			Name:
Ward	ł:			NHI:
Toci	lizur	nab -	con	tinued
Re-a	assess	sment r	equi	onset Still's disease red after 6 months oxes where appropriate)
	0	Prescrit	bed	by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a
and	I			guideline that has been endorsed by the Health NZ Hospital.
			or	 O The patient has had an initial Special Authority approval for adalimumab and/or etanercept for adult-onset Still's disease (AOSD) O The patient has been started on tocilizumab for AOSD in a Health NZ Hospital
		and		
			or	 O The patient has experienced intolerable side effects from adalimumab and/or etanercept O 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 AOSD
	or		_	
		and)	Patient diagnosed with AOSD according to the Yamaguchi criteria (J Rheumatol 1992;19:424-430)
		and	C	Patient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, non-steroidal antiinflammatory drugs (NSAIDs) and methotrexate
			С	Patient has persistent symptoms of disabling poorly controlled and active disease
Re-a	assess	sment r	equi	ticular juvenile idiopathic arthritis red after 4 months oxes where appropriate)
and	I			by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.
			С	The patient has had an initial Special Authority approval for both etanercept and adalimumab for polyarticular course juvenile idiopathic arthritis (JIA)
		and (С	The patient has experienced intolerable side effects, or has received insufficient benefit from, both etanercept and adalimumab
	or			
		and	C	Treatment with a tumour necrosis factor alpha inhibitor is contraindicated
		and	C	Patient has had polyarticular course JIA for 6 months duration or longer
		and	C.	To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance
		anu		O At least 5 active joints and at least 3 joints with limited range of motion, pain or tenderness after a 3-month trial of methotrexate (at the maximum tolerated dose)
			or or	O Moderate or high disease activity (cJADAS10 score of at least 2.5) after a 3-month trial of methotrexate (at the maximum tolerated dose)
			51	O Low disease activity (cJADAS10 score between 1.1 and 2.5) after a 6-month trial of methotrexate

Use this checklist to determine if a patient meets the restrictions for funding in the hospital setting	g. 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:				
Tocilizumab - continued				
INITIATION – idiopathic multicentric Castleman's disease Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a haematologist, rheumatologist or in accordance with a protocol or guideline that has been endorse and	t or Practitioner on the recommendation of a haematologist or rheumatologist, d by the Health NZ Hospital.			
 Patient has severe HHV-8 negative idiopathic multicentric Casand Treatment with an adequate trial of corticosteroids has prover and Tocilizumab to be administered at doses no greater than 8 mg 	ineffective			
INITIATION – moderate to severe COVID-19 Re-assessment required after 1 dose Prerequisites (tick boxes where appropriate)				
 Patient has confirmed (or probable) COVID-19 and Oxygen saturation of < 92% on room air, or requiring supplem and Patient is receiving adjunct systemic corticosteroids, or system 				
and O Tocilizumab is to be administered at doses no greater than 8m and O Tocilizumab is not to be administered in combination with bar	ng/kg IV for a maximum of one dose			
CONTINUATION – Rheumatoid Arthritis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)				
and protocol or guideline that has been endorsed by the Health NZ Hos	on the recommendation of a rheumatologist, or in accordance with a bital.			
or significant response to treatment in the opinion of the physicia	an ast a continuing 30% improvement in active joint count from baseline and			
protocol or guideline that has been endorsed by the Health NZ Hos	on the recommendation of a rheumatologist, or in accordance with a pital.			
and O Following up to 6 months' initial treatment, the patient has achieved at least an American College of Rheumatology paediatric 30 improvement criteria (ACR Pedi 30) response from baseline O On subsequent reapplications, the patient demonstrates at least a continuing ACR Pedi 30 response from baseline				

I confirm that the above details are correct:

Use this checklist to determine if a patient meets the restrictions for funding in the Schedule. For community funding, see the Special Authority Criteria.	he hospital setting. For more details, refer to Section H of the Pharmaceutical
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Tocilizumab - continued	
CONTINUATION – adult-onset Still's disease Re-assessment required after 6 months	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a rheumatologist or Practitioner or protocol or guideline that has been endorsed by the Health NZ Hosp	
O The patient has a sustained improvement in inflammatory markers a	Ind functional status
CONTINUATION – polyarticular juvenile idiopathic arthritis	

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

~

and

and

or

C)	Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a
		protocol or guideline that has been endorsed by the Health NZ Hospital.
and		

Ο	Treatment is to be used as an adjunct to methotrexate therapy	or monother	apy where use	of methotrexate is limited by to	xicity or
	intolerance				

)	Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in
	physician's global assessment from baseline

On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline

CONTINUATION - idiopathic multicentric Castleman's disease

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

O Prescribed by, or recommended by a haematologist, rheumatologist or Practitioner on the recommendation of a haematologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

The treatment remains appropriate and the patient has a sustained improvement in inflammatory markers and functional status

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, re	fer to Section H of the I	Pharmaceutical
Schedule. For community funding, see the Special Authority Criteria.			

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Omalizumab	
INITIATION – severe asthma Re-assessment required after 6 months	
Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a clinical immunologist or respiration endorsed by the Health NZ Hospital.	atory specialist, or in accordance with a protocol or guideline that has been

and		
	໌ and	Patient must be aged 6 years or older
	C	Patient has a diagnosis of severe asthma
	and	Past or current evidence of atopy, documented by skin prick testing or RAST
	and	Total serum human immunoglobulin E (IgE) between 76 IU/mL and 1300 IU/ml at baseline
	and	Proven adherence with optimal inhaled therapy including high dose inhaled corticosteroid (budesonide 1,600 mcg per day or fluticasone propionate 1,000 mcg per day or equivalent), plus long-acting beta-2 agonist therapy (at least salmeterol 50 mcg bd or eformoterol 12 mcg bd) for at least 12 months, unless contraindicated or not tolerated
	and	
		O Patient has received courses of systemic corticosteroids equivalent to at least 28 days treatment in the past 12 months, unless contraindicated or not tolerated
		O Patient has had at least 4 exacerbations needing systemic corticosteroids in the previous 12 months, where an exacerbation is defined as either documented use of oral corticosteroids for at least 3 days or parenteral steroids
	and C and	Patient has an Asthma Control Test (ACT) score of 10 or less
	С	Baseline measurements of the patient's asthma control using the ACT and oral corticosteroid dose must be made at the time of application, and again at around 26 weeks after the first dose to assess response to treatment
\subseteq		

CONTINUATION - severe asthma

Re-assessment required after 6 months **Prerequisites** (tick boxes where appropriate)

O Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and O Ar

An increase in the Asthma Control Test (ACT) score of at least 5 from baseline

O A reduction in the maintenance oral corticosteroid dose or number of exacerbations of at least 50% from baseline

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.

PRES	SCRIB	ER		PATIENT:
Name	Name: Name:		Name:	
Ward:			NHI:	
Oma	lizun	ab - continued		
Re-a	Issessi	- severe chronic sp nent required after 6 m	nonths	
Prer (and	Ор	es (tick boxes where a rescribed by, or recom ndorsed by the Health	mended by a clinical immunologist or derma	atologist, or in accordance with a protocol or guideline that has been
	(and	D Patient must be a	ged 12 years or older	
		and	nt is symptomatic with Urticaria Activity Scor nt has a Dermatology life quality index (DLQ	
	and			
		or O Patient has (> 20 mg p		
	and	or 🔿	o be stopped if inadequate response* followi	ing 4 doses
		O Complete re	esponse* to 6 doses of omalizumab	
Re-a	Issessi	TION – severe chron nent required after 6 n tes (tick boxes where a		
(and		ndorsed by the Health		atologist, or in accordance with a protocol or guideline that has been
	or	O Patient has	previously had a complete response to 6 doses of previously had a complete response* to 6 do relapsed after cessation of omalizumab the	oses of omalizumab

Note: *Inadequate response defined as less than 50% reduction in baseline UAS7 and DLQI score, or an increase in Urticaria Control Test (UCT) score of less than 4 from baseline. Patient is to be reassessed for response after 4 doses of omalizumab. Complete response is defined as UAS7 less than or equal to 6 and DLQI less than or equal to 5; or UCT of 16. Relapse of chronic urticaria on stopping prednisone/ciclosporin does not justify the funding of omalizumab.

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:

Siltuximab

and

Re-a Prer	ATION Issessment required after 6 months equisites (tick boxes where appropriate) O Prescribed by, or recommended by a haematologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
and	
	O Patient has severe HHV-8 negative idiopathic multicentric Castleman's Disease
	and
	O Treatment with an adequate trial of corticosteroids has proven ineffective
	O Siltuximab is to be administered at doses no greater than 11 mg/kg every 3 weeks
\geq	
	ITINUATION Issessment required after 12 months
Prer	equisites (tick box where appropriate)
(O Prescribed by, or recommended by a haematologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

The treatment remains appropriate and the patient has sustained improvement in inflammatory markers and functional status

I confirm that the above details are correct:

Jse 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:	
Obinutuzumab		

INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and \bigcirc The patient has progressive Binet stage A, B or C CD20+ chronic lymphocytic leukaemia requiring treatment and The patient is obinutuzumab treatment naive and The patient is not eligible for full dose FCR due to comorbidities with a score > 6 on the Cumulative Illness Rating Scale (CIRS) or reduced renal function (creatinine clearance < 70mL/min) and Patient has adequate neutrophil and platelet counts* unless the cytopenias are a consequence of marrow infiltration by CLL and Patient has good performance status and Obinutuzumab to be administered at a maximum cumulative dose of 8,000 mg and in combination with chlorambucil for a maximum of 6 cycles Note: Chronic lymphocytic leukaemia includes small lymphocytic lymphoma. Comorbidity refers only to illness/impairment other than CLL induced illness/impairment in the patient. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL disease symptoms a higher ECOG (2 or 3) is acceptable where treatment with obinutuzumab is expected to improve symptoms and improve ECOG score to < 2. greater than or equal to 1.5×10^9 /L and platelets greater than or equal to 75×10^9 /L INITIATION – follicular / marginal zone lymphoma Re-assessment required after 9 months **Prerequisites** (tick boxes where appropriate) Patient has follicular lymphoma or Patient has marginal zone lymphoma and Patient is refractory to or has relapsed within 12 months of a rituximab containing combined chemo-immunotherapy regimen* and \bigcirc Patient has an ECOG performance status of 0-2 and Patient has been previously treated with no more than four chemotherapy regimens and Obinutuzumab to be administered at a maximum dose of 1000 mg for a maximum of 6 cycles in combination with chemotherapy* Note: * includes unapproved indications CONTINUATION - follicular / marginal zone lymphoma Re-assessment required after 24 months

Prerequisites (tick boxes where appropriate)

Patient has no evidence of disease progression following obinutuzumab induction therapy
 Obinutuzumab to be administered at a maximum of 1000 mg every 2 months for a maximum of 2 years
 Obinutuzumab to be discontinued at disease progression

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:			
Pertuzumab				

requis		t required after 12 months (tick boxes where appropriate)
and	0	The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)
	or	O Patient is chemotherapy treatment naive
		O Patient has not received prior treatment for their metastatic disease and has had a treatment free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer
and and	0	The patient has good performance status (ECOG grade 0-1)
and	Ο	Pertuzumab to be administered in combination with trastuzumab
and	Ο	Pertuzumab maximum first dose of 840 mg, followed by maximum of 420 mg every 3 weeks
	\cap	
		Pertuzumab to be discontinued at disease progression
	smen	
assess	ites	N t required after 12 months (tick boxes where appropriate) O The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)
assess	smen	N t required after 12 months (tick boxes where appropriate) O The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)

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:
Cetuximab	
INITIATION Prerequisites (tick boxes where appropriate)	

O	Prescribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that	t has been endc	orsed by the Health	ı NZ
	Hospital.			
and				

and	Patient has locally advanced, non-metastatic, squamous cell cancer of the head and neck
Ο	Patient is contraindicated to, or is intolerant of, cisplatin
and	Patient has good performance status
and	To be administered in combination with radiation therapy

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.

PRESC	RIBE	R		PATIENT:	
Name:				Name:	
Nard:				NHI:	
Aflibe	rcer	ot			
INITIA Re-ass Prerec	TION sessn quisit	– We nent i res (ti	requ ck b bed	Related Macular Degeneration d after 3 months es where appropriate) , or recommended by an ophthalmologist or nurse practitioner, or in accordance with a protocol or guideline that has been he Health NZ Hospital.	en
ind	(_)
			or	O Wet age-related macular degeneration (wet AMD)	
				O Polypoidal choroidal vasculopathy	
			or	Choroidal neovascular membrane from causes other than wet AMD	
		and			
			or	J The patient has developed severe endophthalmitis or severe posterior uveitis following treatment with bevacizumab	
				There is worsening of vision or failure of retina to dry despite three intraocular injections of bevacizumab four weeks apart	6
and There is no structural domage to the control force of the treated ave		here is no structural damage to the central fovea of the treated eye			
	and		С	atient has not previously been treated with ranibizumab for longer than 3 months	
	or				
		(or	С	atient has current approval to use ranibizumab for treatment of wAMD and was found to be intolerant to ranibizumab wit months	hin
		(С	atient has previously* (*before June 2018) received treatment with ranibizumab for wAMD and disease was stable while eatment	on
Re-ass	sessn	nent	requ	t Age Related Macular Degeneration d after 12 months	
Prerec	quisit	es (ti	ck b	es where appropriate)	
O Prescribed by, or recommended by an ophthalmologist or nurse practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.					

O Documented benefit must be demonstrated to continue

Patient's vision is 6/36 or better on the Snellen visual acuity score

There is no structural damage to the central fovea of the treated eye

I confirm that the above details are correct:

and

and

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:			
Aflibercept - continued				
INITIATION - Diabetic Macular Oedema Re-assessment required after 4 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by an ophthalmologist or nurse practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Patient has centre involving diabetic macular oedema (DMO) and O Patient's disease is non responsive to 4 doses of intravitreal bevacizumab when administered 4-6 weekly and O Patient has reduced visual acuity between 6/9 – 6/36 with functional awareness of reduction in vision and O Patient has DMO within central OCT (ocular coherence tomography) subfield > 350 micrometers				
CONTINUATION – Diabetic Macular Oedema Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by an ophthalmologist or nurse prace endorsed by the Health NZ Hospital. and O There is stability or two lines of Snellen visual acuity gain and O There is structural improvement on OCT scan (with reduction and O Patient's vision is 6/36 or better on the Snellen visual acuity so and	ctitioner, or in accordance with a protocol or guideline that has been in intra-retinal cysts, central retinal thickness, and sub-retinal fluid)			
O There is no centre-involving sub-retinal fibrosis or foveal atrop	hy batient has retrialled with at least one injection of bevacizumab and had			

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	ł:				NHI:
Sec	ukin	uma	ıb		
Re-a	asses	smen	t req	re chronic plaque psoriasis, second-line biologic uired after 4 months boxes where appropriate)	
O Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Hospital.					e with a protocol or guideline that has been endorsed by the Health NZ
	and	C t		patient has had an initial Special Authority approval for ad pital, for severe chronic plaque psoriasis	alimumab or etanercept, or has trialled infliximab in a Health NZ
		or	 O The patient has experienced intolerable side effects from adalimumab, etanercept or infliximab O The patient has received insufficient benefit from adalimumab, etanercept or infliximab 		
	and	0	for a		rmatology Quality of Life Index (DLQI) assessment has been completed while still on treatment but no longer than 1 month following cessation of
	and	O	The	most recent PASI or DQLI assessment is no more than 1	month old at the time of application
	CONTINUATION – severe chronic plaque psoriasis, second-line biologic Re-assessment required after 6 months				
Prei	requi	sites	(tick	boxes where appropriate)	
O Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the He Hospital.				e with a protocol or guideline that has been endorsed by the Health NZ	
		or	0	Patient's PASI score has reduced by 75% or more (PAS	75) as compared to baseline PASI prior to commencing secukinumab
		or	0	Patient has a Dermatology Quality of Life Index (DLQI) i commencing secukinumab	mprovement of 5 or more, as compared to baseline DLQI prior to
	and				

O Secukinumab to be administered at a maximum dose of 300 mg monthly

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.

PRES	SCRIBER	PATIENT:					
Name	э:	Name:					
Ward	:	NHI:					
Secu	Secukinumab - continued						
INITI Re-a Prer							
(and	O Prescribed by, or recommended by a dermatologist, or in accordan Hospital.	ce with a protocol or guideline that has been endorsed by the Health NZ					
	O Patient has "whole body" severe chronic plaque psoria: 10, where lesions have been present for at least 6 mor	sis with a Psoriasis Area and Severity Index (PASI) score of greater than ths from the time of initial diagnosis					
	O Patient has severe chronic plaque psoriasis of the face been present for at least 6 months from the time of init	, or palm of a hand or sole of a foot, where the plaque or plaques have ial diagnosis					
	and O Patient has tried, but had an inadequate response (see Note) following (at maximum tolerated doses unless contraindicated and	to, or has experienced intolerable side effects from, at least three of the d): phototherapy, methotrexate, ciclosporin, or acitretin					
	A PASI assessment or Dermatology Quality of Life Index (DLQI) assessment has been completed for at least the most recent prior treatment course, preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course and						
	O The most recent PASI or DQLI assessment is no more than 1						
psori recei and s	iasis, a PASI score of greater than 10, as assessed preferably while still						
Re-a	ITINUATION – severe chronic plaque psoriasis, first-line biologic assessment required after 6 months equisites (tick boxes where appropriate)						
		ce with a protocol or guideline that has been endorsed by the Health NZ					
		SI 75) as compared to baseline PASI prior to commencing secukinumab					
	Or Patient has a Dermatology Quality of Life Index (DLQI) commencing secukinumab	improvement of 5 or more, as compared to baseline DLQI prior to					
	And O Secukinumab to be administered at a maximum dose of 300	mg monthly					
Re-a	IATION – ankylosing spondylitis, second-line biologic assessment required after 3 months requisites (tick boxes where appropriate)						
(and	O Prescribed by, or recommended by a rheumatologist, or in accorda Hospital.	nce with a protocol or guideline that has been endorsed by the Health NZ					
	O The patient has had an initial Special Authority approval for a	dalimumab and/or etanercept for ankylosing spondylitis					
	O The patient has experienced intolerable side effects fro						
	O Following 12 weeks of adalimumab and/or etanercept to and/or etanercept for ankylosing spondylitis	reatment, the patient did not meet the renewal criteria for adalimumab					

Signed:	Date:
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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:				
Secu	ıkinu	ımab	- continued	
Re-a	ssess equisi	ment r ites (ti Prescril Hospita	 ankylosing spondylitis, second-line biologic quired after 6 months (boxes where appropriate) ed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ clowing 12 weeks initial treatment of secukinumab treatment, BASDAI has improved by 4 or more points from pre-secukinumab seline on a 10 point scale, or by 50%, whichever is less cysician considers that the patient has benefitted from treatment and that continued treatment is appropriate cukinumab to be administered at doses no greater than 150 mg monthly 	
Re-a	ssess equisi	ment r ites (ti	riatic arthritis quired after 6 months < boxes where appropriate) ed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ	
		(and	 Patient has had an initial Special Authority approval for adalimumab, etanercept or infliximab for psoriatic arthritis O Patient has experienced intolerable side effects from adalimumab, etanercept or infliximab O Patient has received insufficient benefit from adalimumab, etanercept or infliximab to meet the renewal criteria for adalimumab, etanercept or infliximab for psoriatic arthritis 	
	or	(and (and (and	 Patient has had severe active psoriatic arthritis for six months duration or longer Patient has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a maximum tolerated dose Patient has tried and not responded to at least three months of sulfasalazine at a dose of at least 2 g per day or leflunomide at a dose of up to 20 mg daily (or maximum tolerated doses) Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen, tender joints Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip 	
			 Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application Patient has an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months 	

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.

PRESCRI	BER			PATIENT:
Name:				Name:
Ward:				NHI:
Secukin	uma	b - c	ontinued	
Re-asses Prerequis	smen sites	t requ (tick b cribed	soriatic arthritis ired after 6 months ioxes where appropriate) by, or recommended by a rheumatologist, or in accordance	ce with a protocol or guideline that has been endorsed by the Health NZ
and	d Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline clinically significant response to treatment in the opinion of the physician or O The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically s response to prior secukinumab treatment in the opinion of the treating physician			
and	o ^t	Secu	kinumab to be administered at doses no greater than 300	mg monthly

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:		

Trastuzumab emtansine

Ο	Patient has early breast cancer expressing HER2 IHC3+ or ISH+
and O	Documentation of pathological invasive residual disease in the breast and/or auxiliary lymph nodes following completion of surgery
and O	Patient has completed systemic neoadjuvant therapy with trastuzumab and chemotherapy prior to surgery
and	Disease has not progressed during neoadjuvant therapy
and O	Patient has left ventricular ejection fraction of 45% or greater
and	Adjuvant treatment with trastuzumab emtansine to be commenced within 12 weeks of surgery
and O	Trastuzumab emtansine to be discontinued at disease progression
	Total adjuvant treatment duration must not exceed 42 weeks (14 cycles)

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

and	Ο	Patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)		
and	Ο	Patient has previously received trastuzumab and chemotherapy, separately or in combination		
und		O The patient has received prior therapy for metastatic disease*		
	or	O The patient developed disease recurrence during, or within six months of completing adjuvant therapy*		
and	Ο	Patient has a good performance status (ECOG 0-1)		
		O Patient does not have symptomatic brain metastases		
	or	O Patient has brain metastases and has received prior local CNS therapy		
and	0	Patient has not received prior funded trastuzumab emtansine treatment		
and	0	Treatment to be discontinued at disease progression		
CONTINUATION – metastatic breast cancer Re-assessment required after 6 months				
Prerequis	Prerequisites (tick boxes where appropriate)			

O The cancer has not progressed at any time point during the previous approval period whilst on trastuzumab emtansine

Treatment to be discontinued at disease progression

Note: *Note: Prior or adjuvant therapy includes anthracycline, other chemotherapy, biological drugs, or endocrine therapy.

and

RS1973 - Rituximab

ABO-incompatible organ transplant - INITIATION	352
ANCA associated vasculitis - INITIATION	
ANCA associated vasculitis - CONTINUATION	
Antibody-mediated organ transplant rejection - INITIATION	352
B-cell acute lymphoblastic leukaemia/lymphoma* - INITIATION	
CD20+ low grade or follicular B-cell NHL - INITIATION	357
CD20+ low grade or follicular B-cell NHL - CONTINUATION	358
Chronic lymphocytic leukaemia - INITIATION	347
Chronic lymphocytic leukaemia - CONTINUATION	348
Membranous nephropathy - INITIATION	
Membranous nephropathy - CONTINUATION	
Neuromyelitis Optica Spectrum Disorder (NMOSD) - INITIATION	
Neuromyelitis Optica Spectrum Disorder (NMOSD) - CONTINUATION	
Severe Refractory Myasthenia Gravis - INITIATION	
Severe Refractory Myasthenia Gravis - CONTINUATION	
Severe antisynthetase syndrome - INITIATION	
Severe antisynthetase syndrome - CONTINUATION	356
Steroid dependent nephrotic syndrome (SDNS) or frequently relapsing nephrotic syndrome (FRNS) - INI	
353	
Steroid dependent nephrotic syndrome (SDNS) or frequently relapsing nephrotic syndrome (FRNS) - CON	TINUATIO
353	
Steroid resistant nephrotic syndrome (SRNS) - INITIATION	353
Steroid resistant nephrotic syndrome (SRNS) - CONTINUATION	354
Aggressive CD20 positive NHL - INITIATION	346
Aggressive CD20 positive NHL - CONTINUATION	347
Anti-NMDA receptor autoimmune encephalitis - INITIATION	357
Anti-NMDA receptor autoimmune encephalitis - CONTINUATION	357
Desensitisation prior to transplant - INITIATION	359
Graft versus host disease - INITIATION	356
Haemophilia with inhibitors - INITIATION	345
Haemophilia with inhibitors - CONTINUATION	345
Immune thrombocytopenic purpura (ITP) - INITIATION	349
Immune thrombocytopenic purpura (ITP) - CONTINUATION	
Immunoglobulin G4-related disease (IgG4-RD*) - INITIATION	360
Immunoglobulin G4-related disease (IgG4-RD*) - CONTINUATION	360
Indolent low-grade lymphomas or bairy cell leukaemia* - INITIATION	346
Indolent, low-grade lymphomas or hairy cell leukaemia* - CONTINUATION	346
Pemiphigus* - INITIATION	359
Pemiphigus* - CONTINUATION	360
Post-transplant - INITIATION	345
Post-transplant - CONTINUATION	345
Pure red cell aplasia (PRCA) - INITIATION	
Pure red cell aplasia (PRCA) - CONTINUATION	
Severe chronic inflammatory demyelinating polyneuropathy - INITIATION	
Severe chronic inflammatory demyelinating polyneuropathy - CONTINUATION	356
Severe cold haemagglutinin disease (CHAD) - INITIATION	348
Severe cold haemagglutinin disease (CHAD) - CONTINUATION	348
Thrombotic thrombocytopenic purpura (TTP) - INITIATION	350
Thrombotic thrombocytopenic purpura (TTP) - CONTINUATION	350
Treatment refractory systemic lupus erythematosus (SLE) - INITIATION	352
Treatment refractory systemic lupus erythematosus (SLE) - CONTINUATION	352
Warm autoimmune haemolytic anaemia (warm AIHA) - INITIATION	
Warm autoimmune haemolytic anaemia (warm AIHA) - CONTINUATION	349

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:				
Rituximab (Riximyo)				
INITIATION – haemophilia with inhibitors Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a haematologist, or in accordance Hospital. and O Patient has mild congenital haemophilia complicated by inhibite or O or O Patient has severe congenital haemophilia complicated by inhibite or O or O Patient has acquired haemophilia O Patient has acquired haemophilia or O Patient has acquired haemophilia O Patient has acquired haemophilia				
 Prescribed by, or recommended by a haematologist, or in accordance Hospital. and Patient was previously treated with rituximab for haemophilia wand An initial response lasting at least 12 months was demonstrate and Patient now requires repeat treatment 				
INITIATION – post-transplant Prerequisites (tick boxes where appropriate)				
O The patient has B-cell post-transplant lymphoproliferative disor and O To be used for a maximum of 8 treatment cycles Note: Indications marked with * are unapproved indications.	der*			
CONTINUATION – post-transplant Prerequisites (tick boxes where appropriate)				
O The patient has had a rituximab treatment-free interval of 12 m and The patient has B-cell post-transplant lymphoproliferative disor and To be used for no more than 6 treatment cycles Note: Indications marked with * are unapproved indications.				

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:
Rituximab (Riximyo) - continued	
INITIATION – indolent, low-grade lymphomas or hairy cell leukaemia* Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)	
To be used for a maximum of 6 treatment cycles	ukaemia* with relapsed disease following prior chemotherapy
or O The patient has indolent, low grade lymphoma or hairy and O To be used for a maximum of 6 treatment cycles	cell leukaemia* requiring first-line systemic chemotherapy
Note: 'Indolent, low-grade lymphomas' includes follicular, mantle, marginal z indication. 'Hairy cell leukaemia' also includes hairy cell leukaemia variant.	cone and lymphoplasmacytic/Waldenstrom macroglobulinaemia. *Unapproved
CONTINUATION – indolent, low-grade lymphomas or hairy cell leukaen Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	nia*
 The patient has had a rituximab treatment-free interval of 12 and The patient has indolent, low-grade NHL or hairy cell leukae and To be used for no more than 6 treatment cycles 	
Note: 'Indolent, low-grade lymphomas' includes follicular, mantle, marginal z indication. 'Hairy cell leukaemia' also includes hairy cell leukaemia variant.	cone and lymphoplasmacytic/Waldenstrom macroglobulinaemia. *Unapproved
INITIATION – aggressive CD20 positive NHL Prerequisites (tick boxes where appropriate)	
The patient has treatment naive aggressive CD20 pos and To be used with a multi-agent chemotherapy regimen and To be used for a maximum of 8 treatment cycles	
or The patient has aggressive CD20 positive NHL with re and To be used for a maximum of 6 treatment cycles Note: 'Aggressive CD20 positive NHL' includes large B-cell lymphoma and E	

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.

PRESCRIE	BER	PATIENT:
Name:	lame: Name:	
Ward:		NHI:
Rituxima	1 b (F	Riximyo) - <i>continued</i>
		DN – aggressive CD20 positive NHL (tick boxes where appropriate)
and	0	The patient has had a rituximab treatment-free interval of 12 months or more The patient has relapsed refractory/aggressive CD20 positive NHL
and	0	To be used with a multi-agent chemotherapy regimen given with curative intent
and	0	To be used for a maximum of 4 treatment cycles
Note: 'Agg	gress	sive CD20 positive NHL' includes large B-cell lymphoma and Burkitt's lymphoma/leukaemia.
Re-assess	men	Chronic lymphocytic leukaemia tt required after 12 months (tick boxes where appropriate)
and		The patient has progressive Binet stage A, B or C chronic lymphocytic leukaemia (CLL) requiring treatment
	or	O The patient is rituximab treatment naive
		O The patient is chemotherapy treatment naive
		O The patient's disease has relapsed following no more than three prior lines of chemotherapy treatment and
		O The patient has had a treatment-free interval of 12 months or more if previously treated with fludarabine and cyclophosphamide chemotherapy
	or	O The patient's disease has relapsed within 36 months of previous treatment and rituximab treatment is to be used in combination with funded venetoclax
and and	0	The patient has good performance status
	or	O The patient does not have chromosome 17p deletion CLL
		O Rituximab treatment is to be used in combination with funded venetoclax for relapsed/refractory chronic lymphocytic leukaemia
and	0	Rituximab to be administered in combination with fludarabine and cyclophosphamide, bendamustine or venetoclax for a maximum of 6 treatment cycles
	0	It is planned that the patient receives full dose fludarabine and cyclophosphamide (orally or dose equivalent intravenous administration), bendamustine or venetoclax
standard th temporarily	hera y del	lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma. A line of chemotherapy treatment is considered to comprise a known peutic chemotherapy regimen and supportive treatments. 'Good performance status' means ECOG score of 0-1, however, in patients bilitated by their CLL disease symptoms a higher ECOG (2 or 3) is acceptable where treatment with rituximab is expected to improve improve ECOG score to < 2.

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:
Rituximab (Riximyo) - continued	
CONTINUATION – Chronic lymphocytic leukaemia	
Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
O The patient's disease has relapsed w with funded venetoclax	within 36 months of previous treatment and rituximab treatment is to be used in combination
and The patient's disease has relap	osed following no more than one prior line of treatment with rituximab for CLL
and	of 36 months or more since commencement of initial rituximab treatment
The patient does not have chro	pmosome 17p deletion CLL
\sim	ceives full dose fludarabine and cyclophosphamide (orally or dose equivalent intravenous
6 treatment cycles	on with fludarabine and cyclophosphamide, bendamustine or venetoclax for a maximum of Il lymphocytic lymphoma. A line of chemotherapy treatment is considered to comprise a known e treatments.
INITIATION – severe cold haemagglutinin disease (CHA Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a haematolog Hospital.	(AD) pist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and O Patient has cold haemagglutinin disease*	
and O Patient has severe disease which is charac symptoms	sterized by symptomatic anaemia, transfusion dependence or disabling circulatory
O The total rituximab dose used would not exercise	ceed the equivalent of 375 mg/m2 of body surface area per week for a total of 4 weeks
Note: Indications marked with * are unapproved indications	5.
CONTINUATION – severe cold haemagglutinin disease Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate)	(CHAD)
O Prescribed by, or recommended by a haematolog Hospital.	pist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
O Previous treatment with lower doses of rituation doses (375 mg/m ² weekly for 4 weeks) is r	ximab (100 mg weekly for 4 weeks) have proven ineffective and treatment with higher now planned
$\bigcap_{i=1}^{n}$	tuximab for severe cold haemagglutinin disease*
O An initial response lasting at least 12	months was demonstrated

Note: Indications marked with * are unapproved indications.

Patient now requires repeat treatment

and

Fori		61973	HOSPITAL MEDICINES RESTRICTIONS CHECK	
			determine if a patient meets the restrictions for funding in the hospital se nunity funding, see the Special Authority Criteria.	etting. For more details, refer to Section H of the Pharmaceutical
PRE	SCRIE	BER	PATIENT:	
Name	ə:		Name:	
Ward	:		NHI:	
Ritu	xima	b (Riximy	yo) - continued	
INIT Re-a	IATIO assess	N – warm sment requ	n autoimmune haemolytic anaemia (warm AIHA) uired after 8 weeks	
Prer	equis	ites (tick b	boxes where appropriate)	
and		Prescribed Hospital.	d by, or recommended by a haematologist, or in accordance with a proto	col or guideline that has been endorsed by the Health NZ
		O Patie	ient has warm autoimmune haemolytic anaemia*	
	and and	O One	e of the following treatments has been ineffective: steroids (including if p mg prednisone daily), cytotoxic agents (e.g. cyclophosphamide monoth	
	and	O The	e total rituximab dose used would not exceed the equivalent of 375 mg/n	n2 of body surface area per week for a total of 4 weeks
Note	: Indi	cations ma	narked with * are unapproved indications.	
and	O f	Prescribed Hospital.	boxes where appropriate) d by, or recommended by a haematologist, or in accordance with a proto- vious treatment with lower doses of rituximab (100 mg weekly for 4 weeks) es (375 mg/m ² weekly for 4 weeks) is now planned Patient was previously treated with rituximab for warm autoimmune ha	eks) have proven ineffective and treatment with higher
		and	An initial response lasting at least 12 months was demonstrated	
			Patient now requires repeat treatment	
Note	: Indi	cations ma	narked with * are unapproved indications.	
Re-a	assess requis	sment requ sites (tick b	une thrombocytopenic purpura (ITP) juired after 8 weeks boxes where appropriate) d by, or recommended by a haematologist, or in accordance with a proto	col or guideline that has been endorsed by the Health NZ
		$\boxed{\bigcirc}$	Patient has immune thrombocytopenic purpura* with a platelet count of	of less than or equal to 20,000 platelets per microlitre
		or O	Patient has immune thrombocytopenic purpura* with a platelet count of mucocutaneous bleeding	
	and	O or	Treatment with steroids and splenectomy have been ineffective	
		or	Treatment with steroids has been ineffective and splenectomy is an al	osolute contraindication

O Other treatments including steroids have been ineffective and patient is being prepared for elective surgery (e.g. splenectomy)

O The total rituximab dose used would not exceed the equivalent of 375 mg/m2 of body surface area per week for a total of 4 weeks

Note: Indications marked with * are unapproved indications.

I confirm that the above details are correct:

and

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:
Rituximab (Riximyo) - continued	
CONTINUATION – immune thrombocytopenic purpura (ITP) Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate)	
 Prescribed by, or recommended by a haematologist, or in accordan Hospital. and 	nce with a protocol or guideline that has been endorsed by the Health NZ
O Previous treatment with lower doses of rituximab (100 mg werdoses (375 mg/m ² weekly for 4 weeks) is now planned or	eekly for 4 weeks) have proven ineffective and treatment with higher
Patient was previously treated with rituximab for immur	
An initial response lasting at least 12 months was dem and O Patient now requires repeat treatment	onstrated
Note: Indications marked with * are unapproved indications.	
Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a haematologist, or in accordan Hospital. and	nce with a protocol or guideline that has been endorsed by the Health NZ
The total rituximab dose used would not exceed the equivale	nt of 375 mg/m2 of body surface area per week for a total of 4 weeks
O Patient has thrombotic thrombocytopenic purpura* and thrombocytopenia despite plasma exchange	has experienced progression of clinical symptoms or persistent
	nic purpura* with neurological or cardiovascular pathology
Note: Indications marked with * are unapproved indications.	
CONTINUATION – thrombotic thrombocytopenic purpura (TTP) Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a haematologist, or in accordan Hospital.	nce with a protocol or guideline that has been endorsed by the Health NZ
 Patient was previously treated with rituximab for thrombotic that An initial response lasting at least 12 months was demonstrative 	
And Patient now requires repeat treatment	
The total rituximab dose used would not exceed the equivale	nt of 375 mg/m2 of body surface area per week for a total of 4 weeks
Note: Indications marked with * are unapproved indications.	

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Use this checklist to determine if a patient meets the restrictions for funding in Schedule. For community funding, see the Special Authority Criteria.	the hospital setting . For more details, refer to Section H of the Pharmaceutical
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	. NHI:
Rituximab (Riximyo) - continued	
INITIATION – pure red cell aplasia (PRCA) Re-assessment required after 6 weeks Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a haematologist, or in accordat Hospital. and O Patient has autoimmune pure red cell aplasia* associated with a de Note: Indications marked with * are unapproved indications.	nce with a protocol or guideline that has been endorsed by the Health NZ emonstrable B-cell lymphoproliferative disorder
Hospital.	nce with a protocol or guideline that has been endorsed by the Health NZ sia* associated with a demonstrable B-cell lymphoproliferative disorder and
Note: Indications marked with * are unapproved indications. INITIATION – ANCA associated vasculitis Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate) O Patient has been diagnosed with ANCA associated vasculities and	
and O Induction therapy with daily oral or pulse intravenous of or disease after at least 3 months	ted
Note: Indications marked with * are unapproved indications. CONTINUATION – ANCA associated vasculitis Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate)	
 Patient has been diagnosed with ANCA associated vasculities and Patient has previously responded to treatment with rituxinate and The total rituximab dose would not exceed the equivalent of 	

Note: Indications marked with * are unapproved indications.

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:
Rituximab (Riximyo) - continued	
the Health NZ Hospital.	t, or in accordance with a protocol or guideline that has been endorsed by
and The patient has severe, immediately life- or organ-threatening and The disease has proved refractory to treatment with steroids a and The disease has relapsed following prior treatment for at least mofetil and high dose cyclophosphamide, or cyclophosphamic and Maximum of four 1000 mg infusions of rituximab	at a dose of at least 1 mg/kg 6 months with maximal tolerated doses of azathioprine, mycophenolate
Note: Indications marked with * are unapproved indications.	
CONTINUATION – treatment refractory systemic lupus erythematosus (S Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a rheumatologist or nephrologist the Health NZ Hospital.	SLE)
 Patient's SLE* achieved at least a partial response to the prevand The disease has subsequently relapsed Maximum of two 1000 mg infusions of rituximab Note: Indications marked with * are unapproved indications. 	rious round of prior rituximab treatment
INITIATION – Antibody-mediated organ transplant rejection Prerequisites (tick box where appropriate) O Patient has been diagnosed with antibody-mediated organ transplar Note: Indications marked with * are unapproved indications.	nt rejection*
INITIATION – ABO-incompatible organ transplant Prerequisites (tick box where appropriate) O Patient is to undergo an ABO-incompatible solid organ transplant* Note: Indications marked with * are unapproved indications.	

Use this checklist to determine if a patient meets the restrictions for funding in Schedule. For community funding, see the Special Authority Criteria.	n the hospital setting . For more details, refer to Section H of the Pharmaceutical
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Rituximab (Riximyo) - continued	
Hospital.	ently relapsing nephrotic syndrome (FRNS)
and O Patient is a child with SDNS* or FRNS* and O Treatment with steroids for at least a period of 3 months ha	s been ineffective or associated with evidence of steroid toxicity
and Treatment with mycophenolate for at least a period of 3 mol and	has been ineffective and/or discontinued due to unacceptable side effects nths with no reduction in disease relapses lent of 375 mg/m ² of body surface area per week for a total of 4 weeks
Note: Indications marked with a * are unapproved indications.	
CONTINUATION – Steroid dependent nephrotic syndrome (SDNS) or f Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a nephrologist, or in accordan Hospital.	requently relapsing nephrotic syndrome (FRNS)
 Patient who was previously treated with rituximab for nephr and Treatment with rituximab was previously successful and has relapsed and the patient now requires repeat treatment 	otic syndrome* s demonstrated sustained response for > 6 months, but the condition has
O The total rituximab dose used would not exceed the equival Note: Indications marked with a * are unapproved indications.	lent of 375 mg/m ² of body surface area per week for a total of 4 weeks
INITIATION – Steroid resistant nephrotic syndrome (SRNS) Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a nephrologist, or in accordar	nce with a protocol or guideline that has been endorsed by the Health NZ
and O Patient is a child with SRNS* where treatment with steroids	
and Treatment with tacrolimus for at least 3 months has been in and	
O Genetic causes of nephrotic syndrome have been excluded and	lent of 375 mg/m ² of body surface area per week for a total of 4 weeks
Note: Indications marked with a * are unapproved indications.	

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.

PRES	SCRIBE	ER PATIE	NT:
Name:			
Ward	:		
Ritu	ximab	D (Riximyo) - <i>continued</i>	
Re-a	issessme	TION – Steroid resistant nephrotic syndrome (SRNS) nent required after 8 weeks tes (tick boxes where appropriate)	
and		rescribed by, or recommended by a nephrologist, or in accordance with a pospital.	rotocol or guideline that has been endorsed by the Health NZ
	and	O Patient who was previously treated with rituximab for nephrotic syndro	me*
	and	Treatment with rituximab was previously successful and has demonstr condition has relapsed and the patient now requires repeat treatment	
		J The total rituximab dose used would not exceed the equivalent of 375	mg/m ² of body surface area per week for a total of 4 weeks
Note	: Indicat	ations marked with a * are unapproved indications.	
		nent required after 6 months tes (tick boxes where appropriate) One of the following dose regimens is to be used: 2 doses of 1,000 me weekly for four weeks	g rituximab administered fortnightly, or 4 doses of 375 mg/m2 administered
	o	O The patient has experienced a severe episode or attack of NMC supportive of a severe attack of NMOSD)	SD (rapidly progressing symptoms and clinical investigations
		The patient has experienced a breakthrough attack of NM and The patient is receiving treatment with mycophenolate	DSD
		and O The patients is receiving treatment with corticosteroids	
Re-a	issessme	TION – Neuromyelitis Optica Spectrum Disorder (NMOSD) nent required after 2 years tes (tick boxes where appropriate)	
	O	One of the following dose regimens is to be used: 2 doses of 1,000 m weekly for four weeks	g rituximab administered fortnightly, or 4 doses of 375 mg/m2 administered
	and and	C The patients has responded to the most recent course of rituximab	
		The patient has not received rituximab in the previous 6 months	

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.

PRESC	RIB	ER	PATIENT:
Name:			Name:
Ward:			NHI:
Rituxi	mal	b (R	Riximyo) - <i>continued</i>
Re-ass	sessr	men	Severe Refractory Myasthenia Gravis t required after 2 years (tick boxes where appropriate)
and		resc osp	cribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.
a	(and	С	One of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg once weekly for four weeks, or two 1,000 mg doses given two weeks apart
		or	O Treatment with corticosteroids and at least one other immunosuppressant for at least a period of 12 months has been ineffective
			O Treatment with at least one other immunosuppressant for a period of at least 12 months and
			O Corticosteroids have been trialed for at least 12 months and have been discontinued due to unacceptable side effects
		or or	 cribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital. One of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg once weekly for four weeks, or two 1,000 mg doses given two weeks apart. An initial response lasting at least 12 months was demonstrated O The patient has relapsed despite treatment with corticosteroids and at least one other immunosuppressant for a period of at least 12 months. O The patient's myasthenia gravis has relapsed despite treatment with at least one immunosuppressant for a period of at least 12 months. O Corticosteroids have been trialed for at least 12 months and have been discontinued due to unacceptable side effects.
Re-ass	sessr	men	Severe antisynthetase syndrome t required after 12 months (tick boxes where appropriate)
a	and))	Patient has confirmed antisynthetase syndrome Patient has severe, immediately life or organ threatening disease, including interstitial lung disease
a	and		O Treatment with at least 3 immunosuppressants (oral steroids, cyclophosphamide, methotrexate, mycophenolate, ciclosporin, azathioprine) has not be effective at controlling active disease
		or	O Rapid treatment is required due to life threatening complications
a	and	С	Maximum of four 1,000 mg infusions of rituximab

Rituximab (Rikimyo) - continued CONTINUATION - Severe antisynthetase syndrome Pre-assessment required after 11 months Prerequisites (ick boxes where appropriate) INITIATION - graft versus host disease mand mand mand mand mand Maximum of two cycles of 2 × 1.000 mg infusions of rituximab given two weeks apart INITIATION - graft versus host disease Prerequisites (ick boxes where appropriate) INITIATION - graft versus host disease following transplant mand mand mand mand mand Maximum of two cycles of 2 × 1.000 mg infusions of rituximab given two weeks apart INITIATION - graft versus host disease Prerequisites (ick boxes where appropriate) INITIATION - graft versus host disease following transplant mand mand mand mand mand mand mand mand	July 2024	RESTRICTIONS CHECKLIST
Name:		
Ward NHI: Rituximab (Riximyo) - continued CONTINUATION - Severe antisynthetase syndrome Re-assessment required later 13 months Prerequisites (tick boxes where appropriate) Image: Continued in the patient has not received rituximab in the previous 6 months and minimum of two cycles of 2 + 1.000 mg infusions of rituximab given two weeks apart Image: Continued in two cycles of 2 + 1.000 mg infusions of rituximab given two weeks apart Image: Continued in two cycles of 2 + 1.000 mg infusions of rituximab given two weeks apart Image: Continued in two cycles of 2 + 1.000 mg infusions of rituximab given two weeks apart Image: Continued in two cycles of 2 + 1.000 mg infusions of rituximab given two weeks apart Image: Continued in the previous framework in the optical previous framework in the previous framework in theore of the previous framework is part	PRESCRIBER	PATIENT:
Rituximab (Rismyo) - continued CONTINUATION - Severe antisynthetase syndrome Re-assessment required after 12 months Prerequisite (to boxes where appropriate) Prerequisite (to boxes where appropriate) Image: the state of the state of the previous fluximab treatment with demonstrated improvement in inflammatory markers, musc arength and pulmonary function and and and and method The patient has not received rituximab in the previous 6 months and and method The patient has not received rituximab in the previous 6 months and method Maximum of two cycles of 2 × 1,000 mg infusions of rituximab given two weeks apart INITIATION - graft versus hoat disease Prerequisites (tick boxes where appropriate) Image: method in the previous fluximab disease following transplant and method biological disease Image: method in the previous disease following transplant and method disease Image: method in the previous disease following transplant and method disease Image: method in the previous disease following transplant and method disease Image: method disease	Name:	
CONTINUATION - Severe antisynthetase syndrome Re-assessment required after 12 months Prerequisities (the boxes where appropriate) Prerequisities (the boxes where appropriate) INITIATION - graft versus host disease and and Maximum of two cycles of 2 × 1,000 mg infusions of rituximab given two weeks apart INITIATION - graft versus host disease Prerequisites (tick boxes where appropriate) INITIATION - graft versus host disease Prerequisites (tick boxes where appropriate) INITIATION - graft versus host disease tollowing transplant and Teatment with at least 3 immunosuppressants (oral steroids, ciclosporin, tacrolimus, mycophenolate, sirolimus) has not be effective controlling active disease INITIATION - severe chronic inflammatory demyelinating polyneuropathy Re-assessment required after 6 months Preseruise (tick boxes where appropriate) INITIATION - severe chronic inflammatory demyelinating polyneuropathy Re-assessment required after 6 months Preseruise (tick boxes where appropriate) Preseruise (tick boxes where appropri	Ward:	NHI:
Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Patient's disease has responded to the previous fluximab treatment with demonstrated improvement in inflammatory markers, musc strength and pulmonary function and The patient has not received rituximab in the previous 6 months and Maximum of two cycles of 2 × 1.000 mg infusions of rituximab given two weeks apart INITIATION – graft versus host disease Prerequisites (tick boxes where appropriate) Patient has refractory graft versus host disease following transplant and Treatment with at least 3 immunosuppressants (oral steroids, cloboporin, tacrolimus, mycophenolate, sirolimus) has not be effective controling active disease The total rituximab dose used would not exceed the equivalent of 375 mg/m² of body surface area per week for a total of 4 weeks INITIATION – severe chronic inflammatory demyelinating polyneuropathy Re-assessment required after 6 months Precequisites (tick boxes where appropriate) Precequisites (tick boxes where appropriate) Precequisites (tick boxes where appropriate) Precequisites (tick boxes where appropriate) Pre	Rituximab (F	Riximyo) - <i>continued</i>
strength and pulmonary function The patient has not received rituximab in the previous 6 months Maximum of two cycles of 2 × 1.000 mg infusions of rituximab given two weeks apart MITATION - graft versus host disease Prerequisites (tick boxes where appropriate) Patient has refractory graft versus host disease following transplant The total rituximab does used would not exceed the equivalent of 375 mg/m² of body surface area per week for a total of 4 weeks TINTATION - severe chronic inflammatory demyelinating polyneuropathy Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) The total rituximab does used would not exceed the equivalent of 375 mg/m² of body surface area per week for a total of 4 weeks TINTATION - severe chronic inflammatory demyelinating polyneuropathy Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) The total rituximab does used would not exceed the equivalent of 375 mg/m² of body surface area per week for a total of 4 weeks TINTATION - severe chronic inflammatory demyelinating polyneuropathy Re-assessment required after 6 months Trecequisites (tick boxes where appropriate) The total rituximab does used would not exceed the equivalent of 375 mg/m² of body surface area per week for a total of 14 weeks TINTATION - severe chronic inflammatory demyelinating polyneuropathy (CIPD) and The total rituximab does used to the immunosuppressant (cyclophosphamide, ciclosporin, tacrolimus, mycophenolate) has not been effective at controlling active disease or The alter the sequired due to life threatening complications and One of the following does regimens is to be used: 375 mg/m² of body surface area per week for a total of four weeks, or 500 mg on weekly for four weeks, or to 1.000 mg does given two weeks apart CONTINUATION - severe chronic inflammatory demyelinating polyneuropathy Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) The patient has not received rituximab in the previous fituximab treatment with d	Re-assessmer	t required after 12 months
INITIATION - graft versus host disease Prerequisites (tick boxes where appropriate) and Patient has refractory graft versus host disease following transplant entrolling active disease and Treatment with at least 3 immunosuppressants (oral steroids, ciclosporin, tacrolimus, mycophenolate, sirolimus) has not be effective controlling active disease and The total rituximab dose used would not exceed the equivalent of 375 mg/m² of body surface area per week for a total of 4 weeks INITIATION - severe chronic inflammatory demyelinating polyneuropathy Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and Patient has severe chronic inflammatory demyelinating polyneuropathy (CIPD) and Treatment with steroids and intravenous immunoglobulin and/or plasma exchange has not been effective at controlling active disease or Rapid treatment is required due to life threatening complications and One of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg on weekly for four weeks, or two 1.000 mg doses given two weeks apart CONTINUATION - severe chronic inflammatory demyelinating polyneuropathy Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) One of the following dose regime	and	strength and pulmonary function The patient has not received rituximab in the previous 6 months
Prerequisites (tick boxes where appropriate) Preserved is a severe chronic inflammatory demyelinating polyneuropathy (CIPD) Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Prescribed by a neurologist, or inaccordance with a protoc		Maximum of two cycles of 2 × 1,000 mg infusions of rituximab given two weeks apart
and and and Treatment with at least 3 immunosuppressants (oral steroids, ciclosporin, tacrolimus, mycophenolate, sirolimus) has not be effective controlling active disease INITIATION - severe chronic inflammatory demyelinating polyneuropathy Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and Patient has severe chronic inflammatory demyelinating polyneuropathy (CIPD) and Patient has severe chronic inflammatory demyelinating polyneuropathy (CIPD) and Controlling active disease or Treatment with steroids and intravenous immunoglobulin and/or plasma exchange has not been effective at controlling active disease or Rapid treatment is required due to life threatening complications and One of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg on weekly for four weeks, or two 1,000 mg doses given two weeks apart CONTINUATION - severe chronic inflammatory demyelinating polyneuropathy Re-assessment required after 6 months Prerequisites (lick boxes where appropriate) or Patient has not received rituximab in the previous 6 months		(tick boxes where appropriate)
INITIATION - severe chronic inflammatory demyelinating polyneuropathy Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and Patient has severe chronic inflammatory demyelinating polyneuropathy (CIPD) and Treatment with steroids and intravenous immunoglobulin and/or plasma exchange has not been effective at controlling active disease or Rapid treatment is required due to life threatening complications and One of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg on weekly for four weeks, or two 1.000 mg doses given two weeks apart CONTINUATION - severe chronic inflammatory demyelinating polyneuropathy Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Patient's disease has responded to the previous rituximab treatment with demonstrated improvement in neurological function and Patient's disease has responded to the previous 6 months and The patient has not received rituximab in the previous 6 months	0	Treatment with at least 3 immunosuppressants (oral steroids, ciclosporin, tacrolimus, mycophenolate, sirolimus) has not be effective at controlling active disease
He-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and Patient has severe chronic inflammatory demyelinating polyneuropathy (CIPD) and Image: Control inflammatory demyelinating polyneuropathy (cilophosphamide, ciclosporin, tacrolimus, mycophenolate) has not been effective at controlling active disease or Image: Control inflammatory demyelinating polyneuropathy Re-assessment required after 6 months Image: Control inflammatory demyelinating polyneuropathy Re-assessment required after 6 months Image: Contrel inflammatory demyelinating polyneuropathy <		The total rituximab dose used would not exceed the equivalent of 375 mg/m ² of body surface area per week for a total of 4 weeks
weekly for four weeks, or two 1,000 mg doses given two weeks apart CONTINUATION - severe chronic inflammatory demyelinating polyneuropathy Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Patient's disease has responded to the previous rituximab treatment with demonstrated improvement in neurological function compared to baseline and O Continue O And O And O And O And O Contract of the previous 6 months	Re-assessmer Prerequisites and and or	At required after 6 months (tick boxes where appropriate) cribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Patient has severe chronic inflammatory demyelinating polyneuropathy (CIPD) Image: Constraint of the severe chronic inflammatory demyelinating polyneuropathy (CIPD) Image: Constraint of the severe chronic inflammatory demyelinating polyneuropathy (CIPD) Image: Constraint of the severe chronic inflammatory demyelinating polyneuropathy (CIPD) Image: Constraint of the severe chronic inflammatory demyelinating polyneuropathy (CIPD) Image: Constraint of the severe chronic inflammatory demyelinating polyneuropathy (CIPD) Image: Constraint of the severe chronic inflammatory demyelinating polyneuropathy (CIPD) Image: Constraint of the severe chronic inflammatory demyelinating polyneuropathy (cilphosphamide, ciclosporin, tacrolimus, mycophenolate) has not been effective at controlling active disease Image: Constraint of the severe chronic inflammatory demyelinating complications
Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Patient's disease has responded to the previous rituximab treatment with demonstrated improvement in neurological function compared to baseline and The patient has not received rituximab in the previous 6 months and		
compared to baseline and O The patient has not received rituximab in the previous 6 months and	Re-assessmer	nt required after 6 months
One of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg on weekly for four weeks, or two 1,000 mg doses given two weeks apart	0	compared to baseline The patient has not received rituximab in the previous 6 months One of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg once

I confirm that the above details are correct:

Signed:	. Date:
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			RESTRICTIO	
chec			st to determine if a patient meets the restrictions for funding in community funding, see the Special Authority Criteria.	n the hospital setting . For more details, refer to Section H of the Pharmaceutical
RES	SCRIB	BER		PATIENT:
Vame	e:			Name:
Nard	I:			NHI:
Ritur	xima	b (B	Riximyo) - <i>continued</i>	
INIT Re-a	IATION assess requisi	N – a smen sites Presc	anti-NMDA receptor autoimmune encephalitis nt required after 6 months (tick boxes where appropriate) cribed by, or recommended by a neurologist, or in accordance	e with a protocol or guideline that has been endorsed by the Health NZ
and Hospital. O Patient has severe anti-NMDA receptor autoimmune encephalitis				halitis
	and	or	and At least one other immunosuppressant (cycloph effective at controlling active disease	noglobulin and/or plasma exchange has not been effective at controlling nosphamide, ciclosporin, tacrolimus, mycophenolate) has not been
weekly for four weeks, or two 1,000 mg doses give				m2 of body surface area per week for a total of four weeks, or 500 mg once
Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endors Hospital. and				
and		Presc	cribed by, or recommended by a neurologist, or in accordanc	e with a protocol or guideline that has been endorsed by the Health NZ
and		Presc	cribed by, or recommended by a neurologist, or in accordance bital. Patient's disease has responded to the previous rituximab t	reatment with demonstrated improvement in neurological function
and	۲ (Presc	cribed by, or recommended by a neurologist, or in accordance bital. Patient's disease has responded to the previous rituximab t The patient has not received rituximab in the previous 6 mo	reatment with demonstrated improvement in neurological function nths
and	⊢ (and (Presc	cribed by, or recommended by a neurologist, or in accordance bital. Patient's disease has responded to the previous rituximab t The patient has not received rituximab in the previous 6 mo The patient has experienced a relapse and now requires fu	reatment with demonstrated improvement in neurological function nths rther treatment m2 of body surface area per week for a total of four weeks, or 500 mg once
INIT Re-a	H (and (and (and (IATION		cribed by, or recommended by a neurologist, or in accordance bital. Patient's disease has responded to the previous rituximab to The patient has not received rituximab in the previous 6 mo The patient has experienced a relapse and now requires fu One of the following dose regimens is to be used: 375 mg/	reatment with demonstrated improvement in neurological function nths rther treatment m2 of body surface area per week for a total of four weeks, or 500 mg once
Re-a	H (and (and (and (IATION		cribed by, or recommended by a neurologist, or in accordance bital. Patient's disease has responded to the previous rituximab to The patient has not received rituximab in the previous 6 mo The patient has experienced a relapse and now requires fur One of the following dose regimens is to be used: 375 mg/ weekly for four weeks, or two 1,000 mg doses given two we CD20+ low grade or follicular B-cell NHL ht required after 9 months (tick boxes where appropriate) O The patient has CD20+ low grade or follicular B-cell N	reatment with demonstrated improvement in neurological function nths rther treatment m2 of body surface area per week for a total of four weeks, or 500 mg once

Form RS197 July 2024		L MEDICINES LIST P TIONS CHECKLIST	age 35		
	t to determine if a patient meets the restrictions for funding ommunity funding, see the Special Authority Criteria.	ng in the hospital setting . For more details, refer to Section H of the Pharmace	eutical		
PRESCRIBER		PATIENT:			
Name:		Name:			
Ward:		NHI:			
Rituximab (R	iximyo) - <i>continued</i>				
Re-assessment	N – CD20+ low grade or follicular B-cell NHL required after 24 months				
Prerequisites	(tick boxes where appropriate)				
and _	Rituximab is to be used for maintenance in CD20+ low grachemotherapy	used for maintenance in CD20+ low grade or follicular B-cell NHL following induction with first-line systemic			
	Patient is intended to receive rituximab maintenance therapy for 2 years at a dose of 375 mg/m2 every 8 weeks (maximum of 12 cycles)				
Re-assessment	lembranous nephropathy required after 6 weeks (tick boxes where appropriate)				
or	 Patient has biopsy-proven primary/idiopathic memb Patient has PLA2 antibodies with no evidence of se 	abranous nephropathy* secondary cause, and an eGFR of > 60ml/min/1.73m2			
	Patient remains at high risk of progression to end-stage ki measures (see Note)	kidney disease despite more than 3 months of treatment with conservative			
\cap	The total rituximab dose would not exceed the equivalent	nt of 375mg/m2 of body surface area per week for a total of 4 weeks			
Re-assessment	N – Membranous nephropathy required after 6 weeks (tick boxes where appropriate)				
and	Patient was previously treated with rituximab for membrar	anous nephropathy*			
or	O Treatment with rituximab was previously successful treatment	ul, but the condition has relapsed, and the patient now requires repeat			
	O Patient achieved partial response to treatment and	requires repeat treatment (see Note)			
and	The total rituximab dose used would not exceed the equiv	ivalent of 375 mg/m2 of body surface area per week for a total of 4 weeks			
Note:					
	narked with * are unapproved indications. progression to end-stage kidney disease defined as > 5g/v				
, .			t of		
	c) Conservative measures include renin-angiotensin system blockade, blood-pressure management, dietary sodium and protein restriction, treatment of dyslipidaemia, and anticoagulation agents unless contraindicated or the patient has experienced intolerable side effects.				
d) Partial respo	inse defined as a reduction of proteinuria of at least 50% f	5 from baseline, and between 0.3 grams and 3.5 grams per 24 hours.			

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:			
Rituximab (Riximyo) - continued			
INITIATION – B-cell acute lymphoblastic leukaemia/lymphoma* Re-assessment required after 2 years			
Prerequisites (tick boxes where appropriate)			
O Patient has newly diagnosed B-cell acute lymphoblastic leukaemia/lymphoma*			
O Treatment must be in combination with an intensive chemoth and	O Treatment must be in combination with an intensive chemotherapy protocol with curative intent		
${ m O}~$ The total rituximab dose would not exceed the equivalent of 3	75 mg/m2 per dose for a maximum of 18 doses		
Note: Indications marked with * are unapproved indications.			
INITIATION – desensitisation prior to transplant Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate)			
O Patient requires desensitisation prior to mismatched allogenic stem cell transplant*			
O Patient would receive no more than two doses at 375 mg/m2	of body-surface area		
Note: Indications marked with * are unapproved indications.			
INITIATION – pemiphigus* Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)			
O Prescribed by, or recommended by a dermatologist or relevant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
O Patient has severe rapidly progressive pemphigus			
Is used in combination with systemic corticosteroids (2)) mg/day)		
O Skin involvement is at least 5% body surface are	a		
O Significant mucosal involvement (10 or more muc	cosal erosions) or diffuse gingivitis or confluent large erosions		
O Involvement of two or more mucosal sites			
or			
O Patient has pemphigus and			
	om systemic corticosteroids (20 mg/day) in combination with a steroid		
Note: Indications marked with * are unapproved indications.			

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:			
Rituximab (Riximyo) - continued				
CONTINUATION – pemiphigus* Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)				
O Prescribed by, or recommended by a dermatologist or relevant specialist, or in accordance with a protocol or guideline that has been endor by the Health NZ Hospital.				
O Patient has experienced adequate clinical benefit from ritux ulceration and reduction in corticosteroid requirement and	imab treatment, with improvement in symptoms and healing of skin			
O Patient has not received rituximab in the previous 6 months				
Note: Indications marked with * are unapproved indications.				
INITIATION – immunoglobulin G4-related disease (IgG4-RD*) Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate)				
O Patient has confirmed diagnosis of IgG4-RD*				
or O Treatment with corticosteroids and/or disease modifyi	ng anti-rheumatic drugs for at least 3 months has been ineffective in dnisone equivalent) without relapse ng anti-rheumatic drugs is contraindicated or associated with evidence of			
and O Total rituximab dose used should not exceed a maximum of two 1000 mg infusions of rituximab given two weeks apart				
Note: Indications marked with * are unapproved indications.				
CONTINUATION – immunoglobulin G4-related disease (IgG4-RD*) Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)				
 Treatment with rituximab for IgG4-RD* was previously but the condition has relapsed Patient is receiving maintenance treatment for IgG4-F 	v successful and patient's disease has demonstrated sustained response,			
and O Rituximab re-treatment not to be given within 6 months of p	revious course of treatment			
O Maximum of two 1000 mg infusions of rituximab given two v	veeks apart			
Note: Indications marked with * are unapproved indications.				

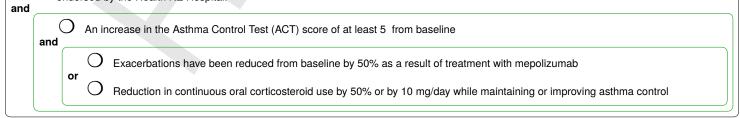
I confirm that the above details are correct:

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.	

RESCRIBER	PATIENT:			
me:	Name:			
ırd:	NHI:			
epolizumab				
ITIATION – Severe eosinophilic asthma e-assessment required after 12 months				
rerequisites (tick boxes where appropriate)				
O Prescribed by, or recommended by a respiratory physician or c endorsed by the Health NZ Hospital.	linical immunologist, or in accordance with a protocol or guideline that has beer			
A Patient must be aged 12 years or older and				
\sim	hma documented by a respiratory physician or clinical immunologist			
\sim	n, central airway obstruction, bronchiolitis etc. have been excluded			
O Patient has a blood eosinophil count of greater than 0.5 -	× 10 [°] 9 cells/L in the last 12 months			
	Patient must be adherent to optimised asthma therapy including inhaled corticosteroids (equivalent to at least 1000 mcg per day of fluticasone propionate) plus long acting beta-2 agonist, or budesonide/formoterol as part of the single maintenance and reliever			
and				
defined as either documented use of oral corticoste	systemic corticosteroids in the previous 12 months, where an exacerbation is eroids for at least 3 days or parenteral corticosteroids			
or O Patient has received continuous oral corticosteroid	s of at least the equivalent of 10 mg per day over the previous 3 months			
and O Treatment is not to be used in combination with subsidise and	m O Treatment is not to be used in combination with subsidised benralizumab			
O Patient has an Asthma Control Test (ACT) score of 10 or less. Baseline measurements of the patient's asthma control using the ACT and oral corticosteroid dose must be made at the time of application, and again at around 52 weeks after the first dose to assess response to treatment				
and	ogical therapy for their severe eosinophilic asthma			
O Patient has not previously received an anti-IL5 biological therapy for their severe eosinophilic asthma or				
O Patient was refractory or intolerant to previou and	us anti-IL5 biological therapy			
O Patient was not eligible to continue treatment 12 months of commencing treatment	t with previous anti-IL5 biological therapy and discontinued within			

Prerequisites (tick boxes where appropriate)

O Prescribed by, or recommended by a respiratory physician or clinical immunologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.



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:
Mepolizumab - continued	
INITIATION – eosinophilic granulomatosis with polyangiitis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
 The patient has eosinophilic granulomatosis with polyangiitis and The patient has trialled and not received adequate benefit from contraindicated to all): azathioprine, cyclophosphamide, leflue 	m at least one of the following for at least three months (unless nomide, methotrexate, mycophenolate, or rituximab
	ee months and is unable to maintain disease control at doses below
CONTINUATION – eosinophilic granulomatosis with polyangiitis Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Patient has no evidence of clinical disease progression	

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:		
Casirivimab and imdevimab			
INITIATION – Treatment of profoundly immunocompromised patients Re-assessment required after 2 weeks			
Prerequisites (tick boxes where appropriate)			
O Patient has confirmed (or probable) COVID-19			
O The patient is in the community (treated as an outpatient) with	th mild to moderate disease severity*		
And Patient is profoundly immunocompromised** and is at risk of not having mounted an adequate response to vaccination against COVID-19 or is unvaccinated			
O Patient's symptoms started within the last 10 days	O Patient's symptoms started within the last 10 days		
	and O Patient is not receiving high flow oxygen or assisted/mechanical ventilation		
O Casirivimab and imdevimab is to be administered at a maxim	num dose of no greater than 2,400 mg		
Note: * Mild to moderate disease severity as described on the Ministry of He ** Examples include B-cell depletive illnesses or patients receiving treatment			
INITIATION – mild to moderate COVID-19-hospitalised patients Re-assessment required after 2 weeks Prerequisites (tick boxes where appropriate)			
O Prescribed by, or recommended by any relevant practitioner, or in a NZ Hospital.	accordance with a protocol or guideline that has been endorsed by the Health		
O Patient has confirmed (or probable) COVID-19			
and O Patient is an in-patient in hospital with mild to moderate dise. and	ase severity*		

O Patient's symptoms started within the last 10 days and _

		Ο	O Age > 50		
	or	Ο	BMI > 30		
	or	Ο	Patient is Māori or Pacific ethnicity		
	or	0	Patient is at increased risk of severe illness from COVID-19, excluding pregnancy, as described on the Ministry of Health website (see Notes)		
and	_				
	or	0 0	Patient is unvaccinated Patient is seronegative where serology testing is readily available or strongly suspected to be seronegative where serology		
			testing is not available		
and			rivimab and imdevimab is to be administered at a maximum dose of no greater than 2,400 mg		

higher-risk-people)

RS1940 - Adalimumab (Amgevita)

Arthritis - oligoarticular course juvenile idiopathic - INITIATION	372
Arthritis - oligoarticular course juvenile idiopathic - CONTINUATION	
Arthritis - polyarticular course juvenile idiopathic - INITIATION	
Arthritis - polyarticular course juvenile idiopathic - CONTINUATION	
Arthritis - psoriatic - INITIATION	
Arthritis - psoriatic - CONTINUATION	
Arthritis - rheumatoid - INITIATION	
Arthritis - rheumatoid - CONTINUATION	
Behcet's disease - severe - INITIATION	
Crohn's disease - adults - INITIATION	
Crohn's disease - adults - CONTINUATION	
Crohn's disease - children - INITIATION	
Crohn's disease - children - CONTINUATION	
Crohn's disease - fistulising - INITIATION	
Crohn's disease - fistulising - CONTINUATION	
Hidradenitis suppurativa - INITIATION	
Hidradenitis suppurativa - CONTINUATION	
Ocular inflammation - chronic - INITIATION	
Ocular inflammation - chronic - CONTINUATION	
Ocular inflammation - severe - INITIATION	
Ocular inflammation - severe - CONTINUATION	
Plaque psoriasis - severe chronic - INITIATION	
Plaque psoriasis - severe chronic - CONTINUATION	
Still's disease - adult-onset (AOSD) - INITIATION	
Ankylosing spondylitis - INITIATION	
Ankylosing spondylitis - CONTINUATION	
Inflammatory bowel arthritis - axial - INITIATION	
Inflammatory bowel arthritis - axial - CONTINUATION	
Inflammatory bowel arthritis – peripheral - INITIATION	
Inflammatory bowel arthritis – peripheral - CONTINUATION	
Inflammatory bowel arthritis – peripheral - CONTINUATION Pyoderma gangrenosum - INITIATION Ulcerative colitis - INITIATION	
Ulcerative colitis - INI HATION	
Undifferentiated spondyloarthiritis - INITIATION	
Undifferentiated spondyloarthiritis - CONTINUATION	
)

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:	

Adalimumab (Amgevita)

			t's disease - severe oxes where appropriate)
and		rescrib Z Hos	by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health I.
	(and	О ті	patient has severe Behcet's disease* that is significantly impacting the patient's quality of life
		or	The patient has severe ocular, neurological, and/or vasculitic symptoms and has not responded adequately to one or more treatment(s) appropriate for the particular symptom(s)

O The patient has severe gastrointestinal, rheumatological and/or mucocutaneous symptoms and has not responded adequately to two or more treatments appropriate for the particular symptom(s)

Note: Indications marked with * are unapproved indications.

INITIATION – Hidradenitis suppurativa

Re-assessment required after 4 months

and

and

Prerequisites (tick boxes where appropriate)

\bigcirc	Prescribed by, or recommended by a dermatologist, or ir	n accordance v	with a protocol or	guideline that has been endorsed by the Health NZ
	Hospital.			
and				

\cup	Patient has hidradenitis suppurativa Hurley Stage II or Hurley Stage III lesions in distinct anatomic areas
and	
\bigcirc	Patient has tried, but had an inadequate response to at least a 90 day trial of systemic antibiotics or patient has demonstrated
Ŭ	intolerance to or has contraindications for systemic antibiotics

O Patient has 3 or more active lesions

The patient has a DLQI of 10 or more and the assessment is no more than 1 month old at time of application

	ONTINUATION – Hidradenitis suppurativa e-assessment required after 2 years
P	rerequisites (tick boxes where appropriate)
a	O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	O The patient has a reduction in active lesions (e.g. inflammatory nodules, abscesses, draining fistulae) of 25% or more from baseline O The patient has a DLQI improvement of 4 or more from baseline

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.	

SCRIE	BER		PATIENT:
ə:			Name:
:			NHI:
limu	mab	(An	ngevita) - continued
assess requis	sment r s ites (ti Prescri	equ ck b bed	e psoriasis - severe chronic red after 4 months oxes where appropriate) by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
г	Hospita	11.	
	(and	С	Patient has had an initial Special Authority approval for etanercept for severe chronic plaque psoriasis
		or	O Patient has experienced intolerable side effects
			O Patient has received insufficient benefit to meet the renewal criteria for etanercept for severe chronic plaque psoriasis
or			
		or	 Patient has "whole body" severe chronic plaque psoriasis with a (PASI) score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis
	and (and	C C	Patient has tried, but had an inadequate response to, or has experienced intolerable side effects from, at least three of the following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, ciclosporin, or acitretin A PASI assessment or (DLQI) assessment has been completed for at least the most recent prior treatment course but no longer than 1 month following cessation of each prior treatment course and is no more than 1 month old at the time of application
assess requis	sment r s ites (ti	equ ck b bed	laque psoriasis - severe chronic red after 2 years oxes where appropriate) by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Hea
	(and	С	Patient had "whole body" severe chronic plaque psoriasis at the start of treatment
		~	O The patient has a PASI score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-adalimumab treatment baseline value
		or	O The patient has a DLQI improvement of 5 or more, when compared with the pre-treatment baseline value
or			
	(and	C	Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment
	1		

O The patient has a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-adalimumab treatment baseline value

July 2	n RS1940 2024	HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST	Page 30
	nis checklist to determine if a patient meets the restric dule. For community funding, see the Special Authori	ctions for funding in the hospital setting . For more details, refer to Section ity Criteria.	H of the Pharmaceutical
PRES	SCRIBER	PATIENT:	
Name	9:	Name:	
Ward	:	NHI:	
Adal	imumab (Amgevita) - continued		
	ATION – pyoderma gangrenosum equisites (tick boxes where appropriate)		
(and	Prescribed by, or recommended by a dermatolog Hospital.	ogist, or in accordance with a protocol or guideline that has been endorsed	by the Health NZ
	O Patient has pyoderma gangrenosum*		
	Patient has received three months of conv azathioprine, or methotrexate) and not rec	ventional therapy including a minimum of three pharmaceuticals (e.g. pred ceived an adequate response	nisone, ciclosporin,
Note	: Indications marked with * are unapproved indication	ns.	
(and	NZ Hospital. Patient has severe active Crohn's disease and Patient has a CDAI score of greater or O Patient has extensive small intestine or O Patient has evidence of short gut sy or O Patient has an ileostomy or colostor and	r than or equal to 300 or HBI score of greater than or equal to 10 e disease affecting more than 50 cm of the small intestine yndrome or would be at risk of short gut syndrome with further bowel resec	tion
Re-a	NZ Hospital.	t practitioner, or in accordance with a protocol or guideline that has been en om the CDAI score, or HBI score has reduced 3 points, from when the patie	
	O CDAI score is 150 or less, or HBI is 4 or le or O The patient has demonstrated an adequat	ess te response to treatment, but CDAI score and/or HBI score cannot be asse	essed

Signed:		Date:	
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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.

			······································	
PRES	SCRIE	BER	F	PATIENT:
Name	e:		M	lame:
Ward	:		N	IHI:
Adal	imu	mał	b (Amgevita) - continued	
Re-a	sses: equis	smer sites	Crohn's disease - children nt required after 6 months s (tick boxes where appropriate)	
and		Preso NZ H	cribed by, or recommended by any relevant practitioner, or in according to the second se	ordance with a protocol or guideline that has been endorsed by the Health
	and	0	Paediatric patient has active Crohn's disease	
		or	\sim	
			O Patient has extensive small intestine disease	
	and	0	Patient has tried but had an inadequate response to, or has expand corticosteroids	erienced intolerable side effects from, prior therapy with immunomodulators
	equis	sites Preso	nt required after 2 years (tick boxes where appropriate) scribed by, or recommended by any relevant practitioner, or in accord Hospital. PCDAI score has reduced by 10 points from the PCDAI score will PCDAI score is 15 or less The patient has demonstrated an adequate response to treatme	
Re-a	sses: equis	smer sites Preso	Crohn's disease - fistulising nt required after 6 months (tick boxes where appropriate) scribed by, or recommended by any relevant practitioner, or in accor- Hospital.	ordance with a protocol or guideline that has been endorsed by the Health
and	and	0	Patient has confirmed Crohn's disease	
		or	O Patient has one or more complex externally draining entern	ocutaneous fistula(e)
		or	O Patient has one or more rectovaginal fistula(e)	
	and		O Patient has complex peri-anal fistula	

O A Baseline Fistula Assessment has been completed and is no more than 1 month old at the time of application

I confirm that the above details are correct:

Signed: Date:

	m R 2024	S1940)				EDICINES LIST NS CHECKLIST	Page 36
					ine if a patient meets th unding, see the Specia		the hospital setting . For more details, r	efer to Section H of the Pharmaceutical
PRE	SCRI	BER					PATIENT:	
Nam	ne:						Name:	
Ward	d:						NHI:	
Ada	limu	ımab	(An	igev	vita) - continued			
Re-	asses	sment	equ	red a	a's disease - fistulising after 2 years where appropriate)	g		
and	_	Prescr NZ Ho			r recommended by any	r relevant practitioner, or in a	ccordance with a protocol or guideline the	hat has been endorsed by the Health
	or	0	here	has	been a marked reducti	ulae have decreased from b ion in drainage of all fistula(on and patient-reported pain	e) from baseline as demonstrated by a re	eduction in the Fistula Assessment
and	_	NZ Ho	pita	atier	nt has had an initial Spe ent has severe uveitis u	ecial Authority approval for in	ccordance with a protocol or guideline the fliximab for chronic ocular inflammation of steroids and other immunosuppressar	·
			or or	000000000000000000000000000000000000000	Patient is under 18 ye	ears and treatment with met ars and treatment with sterc	least two other immunomodulatory agen hotrexate has proven ineffective or is not hids or methotrexate has proven ineffecti prevent irreversible vision loss prior to ac	t tolerated at a therapeutic dose
Re-	asses requi	sment sites (t Prescr NZ Ho	equ ck b bed spita	red a oxes oy, o			ccordance with a protocol or guideline t eks' initial treatment	hat has been endorsed by the Health
		Or	ollo	ving	each 2 year treatment	period, the patient has had	a sustained reduction in inflammation (S	Standardisation of Uveitis

Nomenclature (SUN) criteria < ¹/₂+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema) О

Following each 2 year treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old

or

or

()

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.

PRES	SCRIE	BER	P	ATIENT:				
Name	ə:		N	ame:				
Ward	:		N	HI:				
INIT	ΙΑΤΙΟ	N – O	b (Amgevita) - continued Ocular inflammation - severe nt required after 4 months					
			(tick boxes where appropriate)					
and			cribed by, or recommended by any relevant practitioner, or in acco lospital.	rdance with a protocol or guideline that has been endorsed by the Health				
	or	0	Patient has had an initial Special Authority approval for infliximab	o for severe ocular inflammation				
		and	O Patient has severe, vision-threatening ocular inflammation	requiring rapid control				
			O Treatment with high-dose steroids (intravenous meth ineffective at controlling symptoms	ylprednisolone) followed by high dose oral steroids has proven				
			O Patient developed new inflammatory symptoms while	e receiving high dose steroids				
			or O Patient is aged under 8 years and treatment with hig ineffective at controlling symptoms	h dose oral steroids and other immunosuppressants has proven				
Re-a	assess	sment	DN – Ocular inflammation - severe ht required after 2 years (tick boxes where appropriate)					
and	O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.							
	or	0	The patient has had a good clinical response following 3 initial do	oses				
	or O Following each 2 year treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema)							

Following each 2 year treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old

I confirm that the above details are correct:

Signed: Date:

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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	f the Pharmaceutical
Schedule. For community funding, see the Special Authority Criteria.			

PRESCRIE	BER		PATIENT:
Name:			Name:
Ward:			NHI:
Adalimu	mab (/	Am	ngevita) - continued
Re-assess Prerequis	sment re sites (tic	equi k b	psing spondylitis ired after 6 months oxes where appropriate) by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
	Hospital		, , , , , , , , , , , , , , , , , , ,
	and)	Patient has had an initial Special Authority approval for etanercept for ankylosing spondylitis
		or	O The patient has experienced intolerable side effects
			O The patient has received insufficient benefit to meet the renewal criteria for ankylosing spondylitis
or		<u> </u>	
	and)	Patient has a confirmed diagnosis of ankylosing spondylitis for more than six months
	and)	Patient has low back pain and stiffness that is relieved by exercise but not by rest
)	Patient has bilateral sacroiliitis demonstrated by radiology imaging
	and)	Patient has not responded adequately to treatment with two or more NSAIDs, while patient was undergoing at least 3 months of a regular exercise regimen for ankylosing spondylitis
	and		
			O Patient has limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by the following BASMI measures: a modified Schober's test of less than or equal to 4 cm and lumbar side flexion measurement of less than or equal to 10 cm (mean of left and right)
		or	O Patient has limitation of chest expansion by at least 2.5 cm below the average normal values corrected for age and gender
	and)	A BASDAI of at least 6 on a 0-10 scale completed after the 3 month exercise trial, but prior to ceasing any previous pharmacological treatment and is no more than 1 month old at the time of application
Re-assess	sment re	equi	nkylosing spondylitis ired after 2 years ox where appropriate)

O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

For applications where treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10 point scale, or an improvement in BASDAI of 50%, whichever is less

and

 \bigcirc

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.

PRESCR	IBER	PATIENT:
Name:		Name:
Ward:		NHI:
Adalimu	uma	b (Amgevita) - continued
INITIATIC Re-asses	ON – ssmer isites Pres	Arthritis - oligoarticular course juvenile idiopathic nt required after 6 months (tick boxes where appropriate) cribed by, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed the Health NZ Hospital. The patient has had an initial Special Authority approval for etanercept for oligoarticular course juvenile idiopathic arthritis (JIA)
Re-asses	ssmer isites Pres	DN – Arthritis - oligoarticular course juvenile idiopathic nt required after 2 years (tick boxes where appropriate) cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health dospital.
and	0	Following initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baseline On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline

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:
Adalimumab (Amgevita) - continued	
INITIATION – Arthritis - polyarticular course juvenile idiopathic Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a named specialist or rheumator by the Health NZ Hospital. and	logist, or in accordance with a protocol or guideline that has been endorsed
O Patient has had an initial Special Authority approval for and O Patient has experienced intolerable side effects or O Patient has received insufficient benefit to meet the or	etanercept for polyarticular course juvenile idiopathic arthritis (JIA) ne renewal criteria for polyarticular course JIA
To be used as an adjunct to methotrexate therapy or mo and Patient has had polyarticular course JIA for 6 months du and O At least 5 active joints and at least 3 joints with li methotrexate (at the maximum tolerated dose)	mited range of motion, pain or tenderness after a 3-month trial of ore of at least 2.5) after a 3-month trial of methotrexate (at the
CONTINUATION – Arthritis - polyarticular course juvenile idiopathic Re-assessment required after 2 years Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in ad NZ Hospital.	ccordance with a protocol or guideline that has been endorsed by the Health

O Following initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baseline

On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline

or

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.

PRES	SCRI	BER		PATIENT:	
Name	ə:			Name:	
Ward	:			NHI:	
Ada	limu	mab	(An	ngevita) - continued	
				is - psoriatic red after 6 months	
				oxes where appropriate)	
and		Prescri Hospita		by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ	
		and	0	Patient has had an initial Special Authority approval for etanercept or secukinumab for psoriatic arthritis	
			or	O Patient has experienced intolerable side effects	
				O Patient has received insufficient benefit to meet the renewal criteria for psoriatic arthritis	
	or				
		and and and		0 0	Patient has had active psoriatic arthritis for six months duration or longer Patient has tried and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated) Patient has tried and not responded to at least three months of sulfasalazine or leflunomide at maximum tolerated doses (unless contraindicated) O Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen joints O Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip
		and			
			or or	 Patient has CRP level greater than 15 mg/L measured no more than one month prior to the date of this application Patient has an elevated ESR greater than 25 mm per hour ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months 	
Re-a	asses: requis	sment sites (t	requ ick b ibed	rthritis - psoriatic red after 2 years oxes where appropriate) by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health	
and	or			ving initial treatment, the patient has at least a 50% decrease in swollen joint count from baseline and a clinically significant nse in the opinion of the physician	
				nt demonstrates at least a continuing 30% improvement in swollen joint count from baseline and a clinically significant response opinion of the treating physician	

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 th	e Pharmaceutical
Schedule. For community funding, see the Special Authority Criteria.			

PRESCI	RIBE	R		PATIENT:
Name:				Name:
Ward: .				NHI:
Adalim	num	ab (<i>l</i>	٩m	igevita) - continued
INITIAT Re-asse	rion essmuisiti Hd	and and and and	or	 is -rheumatoid red after 6 months boxes where appropriate) by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ The patient has had an initial Special Authority approval for etanercept for rheumatoid arthritis The patient has experienced intolerable side effects The patient has received insufficient benefit from etanercept to meet the renewal criteria for rheumatoid arthritis Patient has had rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic citrullinated peptide (CCP) articody positive) for six months duration or longer Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance Patient has tried and not responded to at least three months of methotrexate in combination with sulfasalazine and hydroxychloroquine sulphate at maximum tolerated doses (unless contraindicated) Patient has tried and not responded to at least three months of methotrexate in combination with the maximum tolerated dose of ciclosporin Patient has tried and not responded to at least three months of methotrexate in combination with the maximum tolerated dose of ciclosporin Patient has tried and not responded to at least three months of therapy at the maximum tolerated dose of leflunomide alone or in combination with methotrexate Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen joints Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist,
				elbow, knee, ankle, and either shoulder or hip
	NUA	FION -	- A	rthritis - rheumatoid
Re-ass	essm	ient re	qui	pixes where appropriate)

(and	С		cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.
	or	0	Following 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
	51	0	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

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.

PRES	SCRI	BER	PATIENT:
Name	e:		
Ward	:		NHI:
Ada	limu	ımab (A	mgevita) - continued
		sites (tick	s disease - adult-onset (AOSD) boxes where appropriate) d by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and	<u> </u>	Hospital.	
		and	The patient has had an initial Special Authority approval for etanercept and/or tocilizumab for (AOSD)
		o	O Patient has experienced intolerable side effects from etanercept and/or tocilizumab
			O Patient has received insufficient benefit from at least a three-month trial of etanercept and/or tocilizumab
	or	\square	
		and	Patient diagnosed with AOSD according to the Yamaguchi criteria
		and	Patient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, NSAIDs and methotrexate
			Patient has persistent symptoms of disabling poorly controlled and active disease
Re-a	isses	sment req	ative colitis uired after 6 months
Prer	equi		boxes where appropriate)
	\mathbf{O}	Prescribe NZ Hospit	by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health al.
and	and	-	ent has active ulcerative colitis
		Ο	Patient's SCCAI score is greater than or equal to 4
		or O	Patient's PUCAI score is greater than or equal to 20
	ano	O Pati and	ent has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators systemic corticosteroids
	and	\sim	gery (or further surgery) is considered to be clinically inappropriate
	ΙΤΙΝ	JATION –	ulcerative colitis
			uired after 2 years boxes where appropriate)
(С	Prescribe NZ Hospit	by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health al.
and		O The	SCCAI score has reduced by 2 points or more from the SCCAI score when the patient was initiated on biologic therapy
	or	O The	PUCAI score has reduced by 10 points or more from the PUCAI score when the patient was initiated on biologic therapy

Forn July 2	RS1940 HOSPITAL MEDICINES LIST Page 3 4 RESTRICTIONS CHECKLIST
	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 e. For community funding, see the Special Authority Criteria.
PRES	RIBER PATIENT:
Name	Name:
Ward:	NHI:
Adal	umab (Amgevita) - continued
Re-a	ION – undifferentiated spondyloarthiritis essment required after 6 months
Prer	Jisites (tick boxes where appropriate)
and	Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	O Patient has undifferentiated peripheral spondyloarthritis* with active peripheral joint arthritis in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip
	O Patient has tried and not responded to at least three months of each of methotrexate, sulphasalazine and leflunomide, at maximum tolerated doses (unless contraindicated)
	O Patient has a CRP level greater than 15 mg/L measured no more than one month prior to the date of this application or
	O Patient has an ESR greater than 25 mm per hour measured no more than one month prior to the date of this application
	or ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months
Note	ndications marked with * are unapproved indications.
Re-a	NUATION – undifferentiated spondyloarthiritis essment required after 2 years uisites (tick boxes where appropriate)
(and	Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	O Following 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
	O The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response in the opinion of the treating physician
Re-a	ION – inflammatory bowel arthritis – axial essment required after 6 months uisites (tick boxes where appropriate)
(and	Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	O Patient has a diagnosis of active ulcerative colitis or active Crohn's disease
	nd O Patient has axial inflammatory pain for six months or more
	D Patient is unable to take NSAIDs
	nd O Patient has unequivocal sacroiliitis demonstrated by radiological imaging or MRI nd
	Patient has not responded adequately to prior treatment consisting of at least 3 months of an exercise regime supervised by a physiotherapist

Ο A BASDAI of at least 6 on a 0-10 scale completed after the 3 month exercise trial, but prior to ceasing any previous pharmacological treatment

and

Use this checklist to determine if a patient meets the restrictions for funding Schedule. For community funding, see the Special Authority Criteria.	g in the hospital setting . For more details, refer to Section H of the Pharmaceutical
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Adalimumab (Amgevita) - continued	
CONTINUATION – inflammatory bowel arthritis – axial Re-assessment required after 2 years	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by any relevant practitioner, or NZ Hospital.	r in accordance with a protocol or guideline that has been endorsed by the Health
\sim	f 4 or more points from pre-treatment baseline on a 10 point scale, or an
INITIATION – inflammatory bowel arthritis – peripheral Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a rheumatologist, or in accord Hospital. and O Patient has a diagnosis of active ulcerative colitis or active	ordance with a protocol or guideline that has been endorsed by the Health NZ
and Patient has active arthritis in at least four joints from the f sternoclavicular and Patient has tried and not experienced a response to at lead dose (unless contraindicated) and Patient has tried and not experienced a response to at lead contraindicated) and O Patient has a CRP level greater than 15 mg/L measure or O Patient has an ESR greater than 25 mm per hour	following: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder, east three months of methotrexate, or azathioprine at a maximum tolerated east three months of sulphasalazine at a maximum tolerated dose (unless usured no more than one month prior to the date of this application y receiving prednisone therapy at a dose of greater than 5 mg per day and
and NZ Hospital.	r in accordance with a protocol or guideline that has been endorsed by the Health o decrease in active joint count from baseline and a clinically significant

O Patient demonstrates at least a continuing 30% improvement in active joint count from baseline in the opinion of the treating physician

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.

PRESC	RIBER	PATIENT:
Name:		Name:
Ward:		NHI:

Gemtuzumab ozogamicin

INITIATION Prerequisites (tick boxes where appropriate) () Patient has not received prior chemotherapy for this condition and Patient has de novo CD33-positive acute myeloid leukaemia and Patient does not have acute promyelocytic leukaemia and Gemtuzumab ozogamicin will be used in combination with standard anthracycline and cytarabine (AraC) and Patient is being treated with curative intent and Patient's disease risk has been assessed by cytogenetic testing to be good or intermediate and Patient must be considered eligible for standard intensive remission induction chemotherapy with standard anthracycline and cytarabine (AraC) and Gemtuzumab ozogamicin to be funded for one course only (one dose at 3 mg per m² body surface area or up to 2 vials of 5 mg as separate doses)

Note: Acute myeloid leukaemia excludes acute promyelocytic leukaemia and acute myeloid leukaemia that is secondary to another haematological disorder (eg myelodysplasia or myeloproliferative disorder).

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:
Tixagevimab with cilgavimab	

INITIATION

Prerequisites (tick box where appropriate)

Only if patient meets access criteria (as per https://pharmac.govt.nz/Evusheld). Note the supply of treatment is via Pharmac's approved distribution process. Refer to the Pharmac website for more information about this and stock availability ()

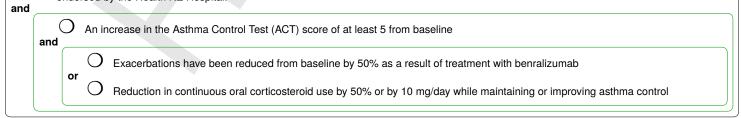
Use this checklist to determine if a patient meets the restrictions for funding in the hospital setting.	For more details, refer to Section H of the Pharmaceutical
Schedule. For community funding, see the Special Authority Criteria.	

	Name:
	NHI:
nab	
ent required after 12 months	
	immunologist, or in accordance with a protocol or guideline that has been
Patient must be aged 12 years or older	
Patient must have a diagnosis of severe eosinophilic asthma d	ocumented by a respiratory physician or clinical immunologist
Conditions that mimic asthma eg. vocal cord dysfunction, cent	tral airway obstruction, bronchiolitis etc. have been excluded
Patient has a blood eosinophil count of greater than $0.5 \times 10^{\circ}9$	ecells/L in the last 12 months
	ing inhaled corticosteroids (equivalent to at least 1000 mcg per day of esonide/formoterol as part of the anti-inflammatory reliever therapy plus
defined as either documented use of oral corticosteroids	nic corticosteroids in the previous 12 months, where an exacerbation is for at least 3 days or parenteral corticosteroids
$\overline{\mathbf{O}}$	t least the equivalent of 10 mg per day over the previous 3 months
Treatment is not to be used in combination with subsidised me	polizumab
Patient has an Asthma Control Test (ACT) score of 10 or less. and oral corticosteroid dose must be made at the time of applic response to treatment	Baseline measurements of the patient's asthma control using the ACT cation, and again at around 52 weeks after the first dose to assess
O Patient has not previously received an anti-IL5 biological	therapy for their severe eosinophilic asthma
O Patient was refractory or intolerant to previous anti and	-IL5 biological therapy
O Patient was not eligible to continue treatment with 12 months of commencing treatment	previous anti-IL5 biological therapy and discontinued within
	 Patient must be aged 12 years or older Patient must have a diagnosis of severe eosinophilic asthma d Conditions that mimic asthma eg. vocal cord dysfunction, cent Patient has a blood eosinophil count of greater than 0.5 × 10°S Patient must be adherent to optimised asthma therapy includir fluticasone propionate) plus long-acting beta-2 agonist, or bud maintenance regimen, unless contraindicated or not tolerated Patient has had at least 4 exacerbations needing system defined as either documented use of oral corticosteroids of a Patient has an Asthma Control Test (ACT) score of 10 or less. and oral corticosteroid dose must be made at the time of appli response to treatment Patient has not previously received an anti-IL5 biological Patient was refractory or intolerant to previous anti O Patient was not eligible to continue treatment with

CONTINUATION – Severe eosinophilic asthma Re-assessment required after 2 years

Prerequisites (tick boxes where appropriate)

O Prescribed by, or recommended by a respiratory physician or clinical immunologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.



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:

Ustekinumab

INITIATION - Crohn's disease - adults Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)
Patient is currently on treatment with ustekinumab commenced prior to 1 February 2023 and met all remaining criteria (criterion 2) below at the time of commencing treatment
O Patient has active Crohn's disease
O Patient has had an initial approval for prior biologic therapy for Crohn's disease and has experienced intolerable side effects or insufficient benefit to meet renewal criteria
O Patient meets the initiation criteria for prior biologic therapies for Crohn's disease and O Other biologics for Crohn's disease are contraindicated
CONTINUATION – Crohn's disease - adults Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)
CDAI score has reduced by 100 points, or HBI score has reduced by 3 points, from when the patient was initiated on biologic therapy or
O CDAI score is 150 or less, or HBI is 4 or less
or O The patient has experienced an adequate response to treatment, but CDAI score and/or HBI score cannot be assessed
and O Ustekinumab to be administered at a dose no greater than 90 mg every 8 weeks
INITIATION – Crohn's disease - children*
Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)
Patient is currently on treatment with ustekinumab commenced prior to 1 February 2023 and met all remaining criteria (criterion 2) below at the time of commencing treatment
O Patient has active Crohn's disease
O Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria
Patient meets the initiation criteria for prior biologic therapies for Crohn's disease
O Other biologics for Crohn's disease are contraindicated
Note: Indication marked with * is an unapproved indication.

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.

ESCRIBER	PATIENT:
1e:	Name:
d:	NHI:
ekinumab - continued	
NTINUATION – Crohn's diseas assessment required after 12 me arequisites (tick boxes where ap	onths
or O PCDAI score i	has reduced by 10 points from when the patient was initiated on biologic therapy s 15 or less as experienced an adequate response to treatment, but CDAI score cannot be assessed
	ninistered at a dose no greater than 90 mg every 8 weeks
te: Indication marked with * is an	unapproved indication.
TIATION – ulcerative colitis assessment required after 6 mon	
Passessment required after 6 molesterequisites (tick boxes where ap Patient is currently of below at the time of	
Assessment required after 6 mole erequisites (tick boxes where ap Patient is currently of below at the time of O Patient has ac and O Patient has ac or O Patient defined of O Patient has ac	propriate) on treatment with ustekinumab commenced prior to 1 February 2023 and met all remaining criteria (criterion 2) commencing treatment
Assessment required after 6 mole erequisites (tick boxes where ap Patient is currently of below at the time of O Patient has ac and O Patient has ac or O Patient defined of O Patient has ac	propriate) on treatment with ustekinumab commenced prior to 1 February 2023 and met all remaining criteria (criterion 2) commencing treatment tive ulcerative colitis nas had an initial approval for prior biologic therapy for ulcerative colitis and has experienced intolerable side or insufficient benefit to meet renewal criteria atient meets the initiation criteria for prior biologic therapies for ulcerative colitis
Assessment required after 6 mole requisites (tick boxes where ap Patient is currently of below at the time of or Patient has ac and O Patient has ac or Patient has ac or Patient has ac or Patient has ac Patient has ac or Patient has ac or or or or Patient has ac or or or or or or or or or or	propriate) In treatment with ustekinumab commenced prior to 1 February 2023 and met all remaining criteria (criterion 2) commencing treatment tive ulcerative colitis has had an initial approval for prior biologic therapy for ulcerative colitis and has experienced intolerable side or insufficient benefit to meet renewal criteria atient meets the initiation criteria for prior biologic therapies for ulcerative colitis ther biologics for ulcerative colitis are contraindicated is propriate)
Assessment required after 6 mole requisites (tick boxes where ap Patient is currently of below at the time of or Patient has act and Patient has act or Patient has act or or or or or or or or or or	propriate) In treatment with ustekinumab commenced prior to 1 February 2023 and met all remaining criteria (criterion 2) commencing treatment tive ulcerative colitis Thas had an initial approval for prior biologic therapy for ulcerative colitis and has experienced intolerable side or insufficient benefit to meet renewal criteria atient meets the initiation criteria for prior biologic therapies for ulcerative colitis ther biologics for ulcerative colitis are contraindicated is ponths

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:

Vedolizumab

(С	Patie	ent has active Crohn's disease
and	_		
		0	Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit meet renewal criteria (unless contraindicated)
	or	Ο	Patient has a CDAI score of greater than or equal to 300, or HBI score of greater than or equal to 10
	or or	Ο	Patient has extensive small intestine disease affecting more than 50 cm of the small intestine
	or	Ο	Patient has evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel resection
		Ο	Patient has an ileostomy or colostomy, and has intestinal inflammation
and	_		
		0	Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response) from prior therapy with immunomodulators and corticosteroids
	or	Ο	Patient has experienced intolerable side effects from immunomodulators and corticosteroids
	or	Ο	Immunomodulators and corticosteroids are contraindicated
'INU/	ATIC)N – C	Crohn's disease - adults
			nired after 2 years
quio			
		0	CDAI score has reduced by 100 points, or HBI score has reduced by 3 points, from when the patient was initiated on biologic therapy
	or	0	CDAI score is 150 or less, or HBI is 4 or less
	or	\cap	The patient has experienced an adequate response to treatment, but CDAI score and/or HBI score cannot be assessed

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	PATIENT:
Name:	Name:
Ward:	NHI:
Vedolizumab - continued	

and Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient be meet renewal criteria (unless contraindicated) Patient has a Paediatric Crohn's Disease Activity Index (PCDAI) score of greater than or equal to 30 Patient has extensive small intestine disease and Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response from prior therapy with immunomodulators and corticosteroids Patient has experienced intolerable side effects from immunomodulators and corticosteroids or Patient has experienced indication. NTINUATION – Crohn's disease - children* -assessment required after 2 years erequisites (tick boxes where appropriate) PCDAI score has reduced by 10 points from when the patient was initiated on biologic therapy PCDAI score is 15 or less	$\int C$)	Paediatric patient has active Crohn's disease
meet renewal criteria (unless contraindicated) or O Patient has a Paediatric Crohn's Disease Activity Index (PCDAI) score of greater than or equal to 30 or O Patient has extensive small intestine disease and O Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial respondulators and corticosteroids or O Patient has experienced intolerable side effects from immunomodulators and corticosteroids or O Patient has experienced intolerable side effects from immunomodulators and corticosteroids or O Patient has experienced indication. vir O Immunomodulators and corticosteroids are contraindicated ex Indication marked with * is an unapproved indication. vir O PCDAI score has reduced by 10 points from when the patient was initiated on biologic therapy or O PCDAI score is 15 or less	and	_	
 Patient has a Paediatric Crohn's Disease Activity Index (PCDAI) score of greater than or equal to 30 Patient has extensive small intestine disease and Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response from prior therapy with immunomodulators and corticosteroids Patient has experienced intolerable side effects from immunomodulators and corticosteroids Patient has experienced intolerable side effects from immunomodulators and corticosteroids Immunomodulators and corticosteroids are contraindicated Indication marked with * is an unapproved indication. TINUATION - Crohn's disease - children* assessment required after 2 years requisites (tick boxes where appropriate) O PCDAI score has reduced by 10 points from when the patient was initiated on biologic therapy O PCDAI score is 15 or less			
O Patient has extensive small intestine disease and O Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response from prior therapy with immunomodulators and corticosteroids or O Patient has experienced intolerable side effects from immunomodulators and corticosteroids or O Patient has experienced intolerable side effects from immunomodulators and corticosteroids or O Patient has experienced intolerable side effects from immunomodulators and corticosteroids inmunomodulators and corticosteroids are contraindicated Indication marked with * is an unapproved indication. ITINUATION - Crohn's disease - children* Issessment required after 2 years equisites (tick boxes where appropriate) O PCDAI score has reduced by 10 points from when the patient was initiated on biologic therapy O PCDAI score is 15 or less			O Patient has a Paediatric Crohn's Disease Activity Index (PCDAI) score of greater than or equal to 30
Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response from prior therapy with immunomodulators and corticosteroids or O Patient has experienced intolerable side effects from immunomodulators and corticosteroids or O Patient has experienced intolerable side effects from immunomodulators and corticosteroids immunomodulators and corticosteroids are contraindicated indication marked with * is an unapproved indication. ITINUATION – Crohn's disease - children* Issessment required after 2 years equisites (tick boxes where appropriate) O PCDAI score has reduced by 10 points from when the patient was initiated on biologic therapy O PCDAI score is 15 or less			$\hat{\mathbf{Q}}$
from prior therapy with immunomodulators and corticosteroids or or O Patient has experienced intolerable side effects from immunomodulators and corticosteroids or O Immunomodulators and corticosteroids are contraindicated E: Indication marked with * is an unapproved indication. ITINUATION – Crohn's disease - children* assessment required after 2 years requisites (tick boxes where appropriate) O PCDAI score has reduced by 10 points from when the patient was initiated on biologic therapy O PCDAI score is 15 or less	and		
 Patient has experienced intolerable side effects from immunomodulators and corticosteroids Immunomodulators and corticosteroids are contraindicated Indication marked with * is an unapproved indication. Intinuation - Crohn's disease - children* assessment required after 2 years requisites (tick boxes where appropriate) PCDAI score has reduced by 10 points from when the patient was initiated on biologic therapy PCDAI score is 15 or less 			
 Immunomodulators and corticosteroids are contraindicated Indication marked with * is an unapproved indication. ITINUATION - Crohn's disease - children* issessment required after 2 years equisites (tick boxes where appropriate) PCDAI score has reduced by 10 points from when the patient was initiated on biologic therapy or PCDAI score is 15 or less 			m O Patient has experienced intolerable side effects from immunomodulators and corticosteroids
ITINUATION - Crohn's disease - children* assessment required after 2 years equisites (tick boxes where appropriate) O PCDAI score has reduced by 10 points from when the patient was initiated on biologic therapy or O PCDAI score is 15 or less			\sim
Assessment required after 2 years requisites (tick boxes where appropriate) O PCDAI score has reduced by 10 points from when the patient was initiated on biologic therapy or O PCDAI score is 15 or less	: Indica	atio	in marked with * is an unapproved indication.
equisites (tick boxes where appropriate) O PCDAI score has reduced by 10 points from when the patient was initiated on biologic therapy or O PCDAI score is 15 or less			
or O PCDAI score is 15 or less			
O PCDAI score is 15 or less			
	•	or	$\hat{\mathbf{O}}$
		or	

O Vedolizumab to administered at a dose no greater than 300mg every 8 weeks

Note: Indication marked with * is an unapproved indication.

and

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:

Vedolizumab - continued

		ulcerative colitis It required after 6 months
Prerequ	sites	(tick boxes where appropriate)
an	O	Patient has active ulcerative colitis
		O Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria (unless contraindicated)
	or	O Patient has a SCCAI score is greater than or equal to 4
		O Patient's PUCAI score is greater than or equal to 20*
an	d	
	0	O Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response) from prior therapy with immunomodulators and corticosteroids
	or	O Patient has experienced intolerable side effects from immunomodulators and corticosteroids
		O Immunomodulators and corticosteroids are contraindicated
Note: Inc	dicatio	on marked with * is an unapproved indication.
Re-asses	ssmer	DN – ulcerative colitis at required after 2 years (tick boxes where appropriate)
		O The SCCAI score has reduced by 2 points or more from the SCCAI score since initiation on biologic therapy
	or	O The PUCAI score has reduced by 10 points or more from the PUCAI score since initiation on biologic therapy *
an	d O	Vedolizumab will be used at a dose no greater than 300 mg intravenously every 8 weeks

Note: Indication marked with * is an unapproved indication.

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:

Brentuximab

Re-assessr	- relapsed/refractory Hodgkin lymphoma nent required after 6 months res (tick boxes where appropriate)
	O Patient has relapsed/refractory CD30-positive Hodgkin lymphoma after two or more lines of chemotherapy and
	O Patient is ineligible for autologous stem cell transplant
	or O Patient has relapsed/refractory CD30-positive Hodgkin lymphoma
	O Patient has previously undergone autologous stem cell transplant
and (D Patient has not previously received funded brentuximab vedotin
(D Response to brentuximab vedotin treatment is to be reviewed after a maximum of 6 treatment cycles
and	D Brentuximab vedotin to be administered at doses no greater than 1.8 mg/kg every 3 weeks
Re-assessr	TION – relapsed/refractory Hodgkin lymphoma nent required after 9 months res (tick boxes where appropriate)
	D Patient has achieved a partial or complete response to brentuximab vedotin after 6 treatment cycles
and (and	D Treatment remains clinically appropriate and the patient is benefitting from treatment and treatment is being tolerated
	D Patient is to receive a maximum of 16 total cycles of brentuximab vedotin treatment
Re-assessr	- anaplastic large cell lymphoma ment required after 9 months res (tick boxes where appropriate)
and	D Patient has relapsed/refractory CD30-positive systemic anaplastic large cell lymphoma
and	D Patient has an ECOG performance status of 0-1

Patient has not previously received brentuximab vedotin

Response to brentuximab vedotin treatment is to be reviewed after a maximum of 6 treatment cycles

Brentuximab vedotin to be administered at doses no greater than 1.8 mg/kg every 3 weeks

)

and

and

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.

PRES	SCRIBER		PATIENT:	
Name):		Name:	
Ward	:		NHI:	•
Brer	tuxima	b - continued		
Re-a	ssessmer	DN – anaplastic large cell lymphoma nt required after 9 months (tick boxes where appropriate)		
	and	Patient has achieved a partial or complete response to brentu	ximab vedotin after 6 treatment cycles	
	Ο	Treatment remains clinically appropriate and the patient is ber	nefitting from treatment and treatment is being tolerated	
	and	Patient is to receive a maximum of 16 total cycles of brentuxin	nab vedotin treatment	

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.

Name:	PRESCRIBER	PATIENT:
Trastuzumab (Herzuma) INITATION - early breast cancer Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Initiation - early breast cancer expressing HER-2 IHC 3+ or ISH + (including FISH or other current technology Maximum cumulative dose of 106 mg/kg (12 months' treatment) Initiation - early breast cancer* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Initiation - early breast cancer* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Initiation - early breast cancer* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Initiation - early breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology and The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology and The patient has not previously received lapatinib treatment for HER-2 positive metastatic breast cancer and The patient has not previously received lapatinib treatment for HER-2 positive metastatic breast cancer and The patient discontinued lapatinib within 3 months due to intolerable side effects and the cancer did not progress whilst or He cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab and Trastuzumab will not be given in combination with pertuzumab and Trastuzumab to be administered in combination with pertuzumab and The patient has not received prior treatment for their metastatic disease and has had a treatment-free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer and The patient has good performance status (ECOG grade 0-1) and The patient has good performance status (ECOG grade 0-1) and The patient has good performance status (ECOG grade 0-1) and The patient has previously discontinued treatment with trastuzumab in the metastatic setting for reasons other than severe toxicity and The patient has previousl	Name:	
INITATION - early breast cancer Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) The patient has early breast cancer expressing HER-2 IHC 3+ or ISH + (including FISH or other current technology and Maximum cumulative dose of 106 mg/kg (12 months' treatment) CONTINUATION - early breast cancer* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology and The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology and The patient has not provide) The patient has not previously received lapatinib treatment for early breast cancer and The patient face of the patient has not previously received lapatinib treatment for HER-2 positive metastatic breast cancer or The patient face of the patient discontinued lapatinib within 3 months due to intolerable side effects and the cancer did not progress whilst on lapatinib or He cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab and or Trastuzumab to be administered in combination with pertuzumab or Trastuzumab to be administered in combination with pertuzumab or Trastuzumab to be discontinued at disease progression or Or Patient has previously discontinued at disease progression or Or Patient has previously discontinued treatment with trastuzumab in the metastatic setting for reasons other than severe toxicity or disease progression	Nard:	NHI:
Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) CONTINUATION - early breast cancer * Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) CONTINUATION - early breast cancer* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) CONTINUATION - early breast cancer* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) CONTINUATION - early breast cancer* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) CONTINUATION - early breast cancer* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) CONTINUATION - early breast cancer* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) CONTINUATION - early breast cancer* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) CONTINUATION - early breast cancer* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) CONTINUATION - early breast cancer* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) CONTINUATION - early breast cancer* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) CONTINUATION - early breast cancer* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) CONTINUATION - early breast cancer* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) CONTINUATION - early breast cancer* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) CONTINUATION - early breast cancer* Re-assessment required after 12 months Re-assessment required after 12 months Re-assessment required after 12 months begins in combination with pertuzumab Re-assessment required after 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer and Re-asterment bit be discontinued at disease progression Re-a	Trastuzumab	(Herzuma)
and Maximum cumulative dose of 106 mg/kg (12 months' treatment) CONTINUATION - early breast cancer* Re-assessment required after 12 months Prerequisites (lick boxes where appropriate) Image: Control of the patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology and the patient received prior adjuvant trastuzumab treatment for early breast cancer Image: Control of the patient has not previously received lapatinib treatment for HER-2 positive metastatic breast cancer Image: Control of the patient discontinued lapatinib within 3 months due to intolerable side effects and the cancer did not progress whilst on lapatinib Image: Control of the patient has not previously received at any time point during the previous 12 months whilst on trastuzumab Image: Control of the patient discontinued lapatinib within 3 months due to intolerable side effects and the cancer did not progress whilst on lapatinib Image: Control of trastuzumab will not be given in combination with pertuzumab Image: Control of trastuzumab will not be given in combination with pertuzumab Image: Control of trastuzumab to be administered in combination with pertuzumab Image: Control of trastuzumab to be discontinued at disease progression Image: Control of the patient has good performance status (ECOG grade 0-1) Image: Control of trastuzumab to be discontinued at disease progression Image: Control of trastuzumab to be discontinued treatment with trastuzumab in the metastatic setting for reas	Re-assessment	required after 12 months
Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology The patient received prior adjuvant trastuzumab treatment for early breast cancer and The patient has not previously received lapatinib treatment for HER-2 positive metastatic breast cancer or The patient discontinued lapatinib within 3 months due to intolerable side effects and the cancer did not progress whilst or He cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab and or Trastuzumab will not be given in combination with pertuzumab and Patient has not received prior treatment for their metastatic disease and has had a treatment-free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer and Trastuzumab to be discontinued at disease progression or Patient has previously discontinued treatment with trastuzumab in the metastatic setting for reasons other than severe toxicity or disease progression	and	
 and the patient received prior adjuvant trastuzumab treatment for early breast cancer and the patient has not previously received lapatinib treatment for HER-2 positive metastatic breast cancer or the patient discontinued lapatinib within 3 months due to intolerable side effects and the cancer did not progress whilst on lapatinib or He cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab and the cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab and trastuzumab will not be given in combination with pertuzumab or Trastuzumab to be administered in combination with pertuzumab and Patient has not received prior treatment for their metastatic disease and has had a treatment-free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer and The patient has good performance status (ECOG grade 0-1) and The patient has previously discontinued at disease progression or Trastuzumab to be discontinued at disease progression 	Re-assessment	required after 12 months
or or or or or or or or	and	 The patient received prior adjuvant trastuzumab treatment for early breast cancer The patient has not previously received lapatinib treatment for HER-2 positive metastatic breast cancer The patient discontinued lapatinib within 3 months due to intolerable side effects and the cancer did not progress whilst on lapatinib He cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab
or O Trastuzumab to be discontinued at disease progression O Patient has previously discontinued treatment with trastuzumab in the metastatic setting for reasons other than severe toxicity or disease progression and		or Trastuzumab to be administered in combination with pertuzumab and Patient has not received prior treatment for their metastatic disease and has had a treatment-free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer and
or disease progression and		O Trastuzumab to be discontinued at disease progression
and O Disease has not progressed during previous treatment with trastuzumab		or disease progression Patient has signs of disease progression
Note: * For patients with relapsed HER-2 positive disease who have previously received adjuvant trastuzumab for early breast cancer	Note: * For patie	ents with relapsed HER-2 positive disease who have previously received adjuvant trastuzumab for early breast cancer

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:
Trastuzumab (Herzuma) - continued	

and	Ο	The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)
	ar	O The patient has not previously received lapatinib treatment for HER-2 positive metastatic breast cancer
	or	O The patient discontinued lapatinib within 3 months due to intolerable side effects and the cancer did not progress whilst on lapatinib
and		
	or	O Trastuzumab will not be given in combination with pertuzumab
		O Trastuzumab to be administered in combination with pertuzumab
		O Patient has not received prior treatment for their metastatic disease and has had a treatment-free interval of at least
		12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer and
		The patient has good performance status (ECOG grade 0-1)

CONTINUATION - metastatic breast cancer

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

	and	The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)
	and	The cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab
	O	Trastuzumab to be discontinued at disease progression
or		
	O	Patient has previously discontinued treatment with trastuzumab for reasons other than severe toxicity or disease progression
	and O and	Patient has signs of disease progression
		Disease has not progressed during previous treatment with trastuzumab
	\Box	

The patient has locally advanced or metastatic gastric, gastro-oesophageal junction or oesophageal cancer expressing HER-2 IHC 2+

INITIATION – gastric, gastro-oesophageal junction and oesophageal cancer Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)

Prerequisites (tick boxes where appropriate

 \bigcirc

FISH+ or IHC3+ (or other current technology) and O Patient has an ECOG score of 0-2

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	PATIENT:				
Name:	Name:				
Ward:	NHI:				
Trastuzumab (Herzuma) - continued					
CONTINUATION – gastric, gastro-oesophageal junction and oesophageal cancer Re-assessment required after 12 months					
Prerequisites (tick boxes where appropriate)					
O The cancer has not progressed at any time point during the pr	O The cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab				
And O Trastuzumab to be discontinued at disease progression					

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:
Basiliximab	
INITIATION Prerequisites (tick box where appropriate)	
${ m O}~$ For use in solid organ transplants	

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.

PRESCR	IBER			PATIENT:
Name:				Name:
Ward:				NHI:
Rituxim	ab (N	labthe	era)	
Re-asses Prerequ	ssmer isites	it requ (tick b cribed	natoid arthritis - prior TNF inhibitor use nired after 4 months poxes where appropriate) by, or recommended by a rheumatologist, or in accordance	ce with a protocol or guideline that has been endorsed by the Health NZ
and	an	d or	rheumatoid arthritis O The patient has experienced intolerable side effec	ity approval for at least one of etanercept and/or adalimumab for ts from a reasonable trial of adalimumab and/or etanercept o and/or etanercept, the patient did not meet the renewal criteria for pritis
an	d			
	or	0 0	Rituximab to be used as an adjunct to methotrexate or le Patient is contraindicated to both methotrexate and leflur	
an	and O Maximum of two 1,000 mg infusions of rituximab given two weeks apart			

SCRIBE	R	PATIENT:		
ne:		Name:		
d:		NHI:		
uximab	(Mab	othera) - continued		
		eumatoid arthritis - TNF inhibitors contraindicated equired after 4 months		
		ck boxes where appropriate)		
	escrib spital	bed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ I.		
and) Tre	reatment with a Tumour Necrosis Factor alpha inhibitor is contraindicated		
and	O Patient has had severe and active erosive rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic citrullinated peptide (CCP) antibody positive) for six months duration or longer			
and	O Patient has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a maximum tolerated dose			
and	Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with sulfasalazine and hydroxychloroquine sulphate (at maximum tolerated doses)			
	or	Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with the maximum tolerated dose of cyclosporin		
	or	Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with intramuscula gold		
	\sim	Patient has tried and not responded to at least three months of therapy at the maximum tolerated dose of leflunomide alone or in combination with oral or parenteral methotrexate		
and				
	or	Patient has persistent symptoms of poorly controlled and active disease in at least 20 swollen, tender joints		
		Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip		
and	~			
	or (Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application		
		C-reactive protein levels not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months		
and	~			
	or	A Rituximab to be used as an adjunct to methotrexate or leflunomide therapy		
	C	${\sf O}$ Patient is contraindicated to both methotrexate and leflunomide, requiring rituximab monotherapy to be used		

O Maximum of two 1,000 mg infusions of rituximab given two weeks apart

I confirm that the above details are correct:

and

Signed: Date:

CRIE	BER			PATIENT:	
:				Name:	
				NHI:	
cima	ab (N	labth	era) - continued		
TINU ssess equis	ATIC smen sites	N – r t requ (tick k	heumatoid arthritis - re-treatment in 'partial responsive nired after 4 months boxes where appropriate)	onders' to rituximab	
	Hosp				
	At 4 months following the initial course of rituximab infusions the patient had between a 30% and 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician				
	or	O	At 4 months following the second course of rituxima from baseline and a clinically significant response to	ab infusions the patient had at least a 50% decrease in active joint count o treatment in the opinion of the physician	
		0		urses of rituximab infusions, the patient demonstrates at least a continuing e and a clinically significant response to treatment in the opinion of the	
and O Rituximab re-treatment not to be given within 6 months of the previous course of treatment				f the previous course of treatment	
and	or	0	Rituximab to be used as an adjunct to methotrexate	e or leflunomide therapy	
		Ο	Patient is contraindicated to both methotrexate and	leflunomide, requiring rituximab monotherapy to be used	
and	0	Maxi	mum of two 1,000 mg infusions of rituximab given tw	vo weeks apart	
ssess equis	smen sites	t requ (tick b cribed	heumatoid arthritis - re-treatment in 'responders' uired after 4 months boxes where appropriate) by, or recommended by a rheumatologist, or in acco	" to rituximab	
	or	0	At 4 months following the initial course of rituximab baseline and a clinically significant response to treat	infusions the patient had at least a 50% decrease in active joint count from atment in the opinion of the physician	
		0		courses of rituximab infusions, the patient demonstrates at least a continuing e and a clinically significant response to treatment in the opinion of the	
and and	O Rituximab re-treatment not to be given within 6 months of the previous course of treatment				
	or	0	Rituximab to be used as an adjunct to methotrexate	e or leflunomide therapy	
		\sim	Patient is contraindicated to both methotrexate and		

RS1922 - Adalimumab (Humira - Alternative brand)

Arthritis - polyarticular course juvenile idiopathic - INITIATION	405
Arthritis - polyarticular course juvenile idiopathic - INTIATION	
Arthritis - psoriatic - INITIATION	
Arthritis - psoriatic - CONTINUATION	406
Arthritis – oligoarticular course juvenile idiopathic - INITIATION	404
Arthritis – oligoarticular course juvenile idiopathic - CONTINUATION	405
Arthritis – rheumatoid - INITIATION	406
Arthritis – rheumatoid - CONTINUATION	406
Behcet's disease – severe - INITIATION	
Behcet's disease – severe - CONTINUATION	
Crohn's disease - adult - INITIATION	
Crohn's disease - adult - CONTINUATION	
Crohn's disease - children - INITIATION	
Crohn's disease - children - CONTINUATION	
Crohn's disease - fistulising - INITIATION	
Crohn's disease - fistulising - CONTINUATION	
Hidradenitis suppurativa - INITIATION	
Hidradenitis suppurativa - CONTINUATION	
Ocular inflammation – chronic - INITIATION	
Ocular inflammation – chronic - CONTINUATION	
Ocular inflammation – severe - INITIATION	
Ocular inflammation – severe - CONTINUATION	
Psoriasis - severe chronic plaque - INITIATION	
Psoriasis - severe chronic plaque - CONTINUATION	
Pyoderma gangrenosum - INITIATION	
Pyoderma gangrenosum - CONTINUATION	
Still's disease – adult-onset (AOSD) - INITIATION	407
Still's disease – adult-onset (AOSD) - CONTINUATION	407
Ankylosing spondylitis - INITIATION	404
Ankylosing spondylitis - CONTINUATION	

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:		
Adalimumab (Humira - Alternative brand)		
INITIATION – Behcet's disease – severe Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in ac NZ Hospital. and	ecordance with a protocol or guideline that has been endorsed by the Health	
O The patient has experienced intolerable side effects from	Amgevita P Humira brand of adalimumab for this indication	
and NZ Hospital.	cordance with a protocol or guideline that has been endorsed by the Health	
The patient has had a good clinical response to treatment with and Adalimumab to be administered at doses no greater than 40 n		
INITIATION – Hidradenitis suppurativa Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a dermatologist or Practitioner on the recommendation of a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
or O Patient has developed symptoms of loss of disease con (Amgevita) and clinician attributes this loss of disease read of the patient has received a maximum of 6 months treatment with A and O Patient has received a maximum of 6 months treatment with A	mgevita	
 Patient has previously had a Special Authority approval for the and Adalimumab to be administered at doses no greater than 40 n 		

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:
Adalimumab (Humira - Alternative brand) - continued	
CONTINUATION – Hidradenitis suppurativa Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a dermatologist or Practitioner or or guideline that has been endorsed by the Health NZ Hospital.	n the recommendation of a dermatologist, or in accordance with a protocol
The patient has a reduction in active lesions (e.g. inflammator and The patient has a Dermatology Quality of Life Index improvem	y nodules, abscesses, draining fistulae) of 25% or more from baseline
and Adalimumab is to be administered at doses no greater than 40	
INITIATION – Psoriasis - severe chronic plaque Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a dermatologist or Practitioner or or guideline that has been endorsed by the Health NZ Hospital.	n the recommendation of a dermatologist, or in accordance with a protocol
or	n adalimumab (Amgevita) following a minimum of 4 weeks treatment trol following a minimum of 4 weeks treatment with adalimumab esponse to a change in treatment regimen
and O Patient has received a maximum of 6 months treatment with A and	mgevita
 Patient has previously had a Special Authority approval for the and Adalimumab to be administered at doses no greater than 40 m 	

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:
Adalimumab (Humira - Alternative brand) - continued	
CONTINUATION – Psoriasis - severe chronic plaque Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a dermatologist or Practitioner or or guideline that has been endorsed by the Health NZ Hospital. and	n the recommendation of a dermatologist, or in accordance with a protocol
or Patient had "whole body" severe chronic plaque ps and Following each prior adalimumab treatment more, or is sustained at this level, when com or Following each prior adalimumab treatment improvement of 5 or more, when compared of or Patient had severe chronic plaque psoriasis of the and Following each prior adalimumab treatment for all 3 of erythema, thickness and scaling, treatment course baseline values O Following each prior adalimumab treatment	course the patient has a PASI score which is reduced by 75% or upared with the pre-adalimumab treatment baseline value course the patient has a Dermatology Quality of Life Index (DLQI)
Adalimumab to be administered at doses no greater than 40 m INITIATION – Pyoderma gangrenosum Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
Hospital.	e with a protocol or guideline that has been endorsed by the Health NZ
or	mgevita

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Adalimumab (Humira - Alternative brand) - continued	
CONTINUATION – Pyoderma gangrenosum Re-assessment required after 6 months	
Prerequisites (tick boxes where appropriate)	
\sim	e with a protocol or guideline that has been endorsed by the Health NZ
O The patient has demonstrated clinical improvement and continu	ues to require treatment
A maximum of 8 doses	
INITIATION – Crohn's disease - adult Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a gastroenterologist or Practitione protocol or guideline that has been endorsed by the Health NZ Hospi and	er on the recommendation of a gastroenterologist, or in accordance with a ital.
or And a maximum of 6 months treatment with Amgevita Patient has developed symptoms of loss of disease contri 6 months treatment with Amgevita and clinician attributes or	
Adailmumab to be administered at doses no greater than 40 m	g every 14 days
CONTINUATION – Crohn's disease - adult Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a gastroenterologist or Practitione protocol or guideline that has been endorsed by the Health NZ Hospi and	er on the recommendation of a gastroenterologist, or in accordance with a ital.
O CDAI score has reduced by 100 points from the CDAI score or O CDAI score is 150 or less or O The patient has demonstrated an adequate response to t	

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.

PRES	CRIB	ER		PATIENT:
Name: Name:				
Ward:				
Adal	imur	mak	o (Hu	Imira - Alternative brand) - continued
Re-a	ssess	men	t requ	's disease - children ired after 6 months ireves where concentration
Prere	equis	ites	(TICK D	poxes where appropriate)
and				by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.
		or	0	The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita
		or	Ο	Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen
			Ο	Patient has Crohn's and is considered to be at risk of disease destabilisation if there were to be a change to current treatment
	and (and	0	Patie	ent has previously had a Special Authority approval for the Humira brand of adalimumab for this indication
	(Ο	Adali	mumab to be administered at doses no greater than 40 mg every 14 days
Prere	Эғ	Presc	ribed	by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital. PCDAI score has reduced by 10 points from the PCDAI score when the patient was initiated on adalimumab PCDAI score is 15 or less
	and		Adali	The patient has demonstrated an adequate response to treatment, but PCDAI score cannot be assessed mumab to be administered at doses no greater than 40 mg every 14 days
		_		
Re-a	ssess	men	t requ	a's disease - fistulising nired after 6 months noxes where appropriate)
(and				by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.
			0	The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita
		or	0	Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen
			Ο	Patient has Crohn's and is considered to be at risk of disease destabilisation if there were to be a change to current treatment
and O Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication and		nt has previously had a Special Authority approval for the Humira brand of adalimumab for this indication		
	(Ο	Adali	mumab to be administered at doses no greater than 40 mg every 14 days

Signed:	Date:
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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.

PRES	CRIBER			PATIENT:
Name	Name: Name:			Name:
Ward:				NHI:
Adal	imuma	b (Humir	a - Alternative brand) - continued	
Re-a Prere	ssessmei equisites O Pres	nt required a (tick boxes) cribed by, c	a's disease - fistulising after 6 months where appropriate) r recommended by a gastroenterologist or Practition eline that has been endorsed by the Health NZ Hos	ner on the recommendation of a gastroenterologist, or in accordance with a bital.
and	and O	O The Ass	number of open draining fistulae have decreased fr re has been a marked reduction in drainage of all fis essment score, together with less induration and pa ab to be administered at doses no greater than 40 r	stula(e) from baseline as demonstrated by a reduction in the Fistula tient-reported pain
Re-a Prere	ssessmei equisites O Pres	nt required a tick boxes	ammation – chronic after 12 months where appropriate) r recommended by any relevant practitioner, or in ac	ccordance with a protocol or guideline that has been endorsed by the Health
and	and and O	And Pati max regi O Pati Patient ha	a maximum of 6 months treatment with Amgevita ent has developed symptoms of loss of disease con	Humira brand of adalimumab for this indication
Re-a Prere	ssessmei equisites O Pres	nt required a tick boxes	ar inflammation – chronic after 12 months where appropriate) r recommended by any relevant practitioner, or in ac	ccordance with a protocol or guideline that has been endorsed by the Health
and	or or and	 Foll Uver reso Foll to 	itis Nomenclature (SUN) criteria < ½+ anterior chan olution of uveitic cystoid macular oedema)	has had a sustained reduction in inflammation (Standardisation of ober or vitreous cells, absence of active vitreous or retinal lesions, or has a sustained steroid sparing effect, allowing reduction in prednisone under 18 years old

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	PATIENT:
Name:	Name:
Ward:	NHI:
Adalimumab (Humira - Alternative brand) - continued	
INITIATION – Ocular inflammation – severe Re-assessment required after 12 months	
Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by any relevant practitioner, or in an NZ Hospital.	ccordance with a protocol or guideline that has been endorsed by the Health
O The patient has experienced intolerable side effects from and a maximum of 6 months treatment with Amgevita	n adalimumab (Amgevita) following a minimum of 4 weeks treatment,
	trol following a minimum of 4 weeks treatment with Amgevita, and a nician attributes this loss of disease response to a change in treatment
O Patient has uveitis and is considered to be at risk of visi	on loss if they were to change treatment
and O Patient has previously had a Special Authority approval for the and	Humira brand of adalimumab for this indication
Adalimumab to be administered at doses no greater than 40 r	ng every 14 days
NZ Hospital.	ccordance with a protocol or guideline that has been endorsed by the Health
and O The patient has had a good clinical response following a	3 initial doses
O Following each 12-month treatment period, the patient I Uveitis Nomenclature (SUN) criteria < ½+ anterior char resolution of uveitic cystoid macular oedema)	has had a sustained reduction in inflammation (Standardisation of the or vitreous cells, absence of active vitreous or retinal lesions, or
or Following each 12-month treatment period, the patient I to < 10mg daily, or steroid drops less than twice daily if	nas a sustained steroid sparing effect, allowing reduction in prednisone under 18 years old
Adalimumab to be administered at doses no greater than 40 mg every 14 days	

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	PATIENT:			
Name:	Name:			
Ward: NHI:				
Adalimumab (Humira - Alternative brand) - continued				
INITIATION – ankylosing spondylitis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)				
O Prescribed by, or recommended by a rheumatologist or Practitioner protocol or guideline that has been endorsed by the Health NZ Hos and	on the recommendation of a rheumatologist, or in accordance with a pital.			
or	m adalimumab (Amgevita) following a minimum of 4 weeks treatment			
(Amgevita)	ntrol following a minimum of 4 weeks treatment with adalimumab			
And O Patient has received a maximum of 6 months treatment with <i>and</i>	Amgevita			
O Patient has previously had a Special Authority approval for th	e Humira brand of adalimumab for this indication			
Adalimumab to be administered at doses no greater than 40 m	ng every 14 days			
CONTINUATION – ankylosing spondylitis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a rheumatologist or Practitioner protocol or guideline that has been endorsed by the Health NZ Hos and	on the recommendation of a rheumatologist, or in accordance with a pital.			
O Treatment has resulted in an improvement in BASDAI of 4 or improvement in BASDAI of 50%, whichever is less	more points from pre-treatment baseline on a 10 point scale, or an			
Adalimumab to be administered at doses no greater than 40 m	ng every 14 days			
INITIATION – Arthritis – oligoarticular course juvenile idiopathic Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)				
O Prescribed by, or recommended by a named specialist or rheumato by the Health NZ Hospital.	logist, or in accordance with a protocol or guideline that has been endorsed			
or	m adalimumab (Amgevita) following a minimum of 4 weeks treatment ntrol following a minimum of 4 weeks treatment with adalimumab esponse to a change in treatment regimen			
and O Patient has received a maximum of 6 months treatment with and O Patient has previously had a Special Authority approval for th				

HOSPITAL MEDICINES LIST

July 2024	RESTRICTIONS CHECKLIST
Use this checklist to determine if a patient meets the res Schedule. For community funding, see the Special Aut	strictions for funding in the hospital setting . For more details, refer to Section H of the Pharmaceutical hority Criteria.
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Adalimumab (Humira - Alternative brand)	- continued
CONTINUATION – Arthritis – oligoarticular course Re-assessment required after 6 months	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a named by the Health NZ Hospital.	specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed
O For patients that demonstrate at least a cont assessment from baseline	inuing 30% improvement in active joint count and continued improvement in physician's global
INITIATION – Arthritis - polyarticular course juveni Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	le idiopathic
O Prescribed by, or recommended by a named by the Health NZ Hospital.	I specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed
O Patient has developed symptom	blerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment s of loss of disease control following a minimum of 4 weeks treatment with adalimumab es this loss of disease response to a change in treatment regimen
and O Patient has received a maximum of 6 r and O Patient has previously had a Special A	months treatment with Amgevita Authority approval for the Humira brand of adalimumab for this indication
CONTINUATION – Arthritis - polyarticular course ju Re-assessment required after 6 months Prerequisites (tick box where appropriate)	uvenile idiopathic
O Prescribed by, or recommended by a named by the Health NZ Hospital.	I specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed
\sim	inuing 30% improvement in active joint count and continued improvement in physician's global
	I specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed
and by the Health NZ Hospital.	
or O Patient has developed symptoms	blerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment s of loss of disease control following a minimum of 4 weeks treatment with adalimumab es this loss of disease response to a change in treatment regimen
and O Patient has received a maximum of 6 r and	months treatment with Amgevita
O Patient has previously had a Special A	uthority approval for the Humira brand of adalimumab for this indication
Adalimumab to be administered at dos	ses no greater than 40 mg every 14 days

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:	
Adalimumab (Humira - Alternative brand) - continued		
CONTINUATION – Arthritis - psoriatic Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
O The patient demonstrates at least a continuing 30% improven response to prior adalimumab treatment in the opinion of the and O Adalimumab to be administered at doses no greater than 40 m		
INITIATION – Arthritis – rheumatoid Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)		
O Prescribed by, or recommended by a rheumatologist or Practitioner protocol or guideline that has been endorsed by the Health NZ Hos	on the recommendation of a rheumatologist, or in accordance with a oital.	
or	m adalimumab (Amgevita) following a minimum of 4 weeks treatment trol following a minimum of 4 weeks treatment with adalimumab esponse to a change in treatment regimen	
and O Patient has received a maximum of 6 months treatment with <i>and</i>	Amgevita	
O Patient has previously had a Special Authority approval for the and	e Humira brand of adalimumab for this indication	
O Adalimumab to be administered at doses no greater that	n 40 mg every 14 days	
	ires doses of adalimumab higher than 40 mg every 14 days to maintain	
CONTINUATION – Arthritis – rheumatoid Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a		
protocol or guideline that has been endorsed by the Health NZ Hospital.		
The patient demonstrates at least a continuing 30% improven response to prior adalimumab treatment in the opinion of the and	nent in active joint count from baseline and a clinically significant treating physician	
O Adalimumab to be administered at doses no greater that or O Patient cannot take concomitant methotrexate and require an adequate response	in 40 mg every 14 days ires doses of adalimumab higher than 40 mg every 14 days to maintain	

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:
Adalimumab (Humira - Alternative brand) - continued	
INITIATION – Still's disease – adult-onset (AOSD) Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a rheumatologist or Practitioner protocol or guideline that has been endorsed by the Health NZ Host	on the recommendation of a rheumatologist, or in accordance with a pital.
or or	m adalimumab (Amgevita) following a minimum of 4 weeks treatment ntrol following a minimum of 4 weeks treatment with adalimumab esponse to a change in treatment regimen
and O Patient has received a maximum of 6 months treatment with <i>A</i> and O Patient has previously had a Special Authority approval for the	
CONTINUATION – Still's disease – adult-onset (AOSD)	

Re-assessment required after 6 months **Prerequisites** (tick box where appropriate)

and

O Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

The patient has demonstrated a sustained improvement in inflammatory markers and functional status

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.

PRES	SCR	IBER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Abci	xin	nab		
INITI Prer			(tick boxes where appropriate)	
	or		For use in patients with acute coronary syndromes undergoing	percutaneous coronary intervention
			For use in patients undergoing intra-cranial intervention	
\subseteq				

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:
Nivolumab	

		required after 4 months tick boxes where appropriate)		
and	Presci Hospi	ibed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ al.		
an	-	Patient has metastatic or unresectable melanoma (excluding uveal) stage III or IV		
and O Baseline measurement of overall tumour burden is documented clinically and radiologically and				
an	-	The patient has ECOG performance score of 0-2		
	or	O Patient has not received funded pembrolizumab		
		Patient has received an initial Special Authority approval for pembrolizumab and has discontinued pembrolizumab within 12 weeks of starting treatment due to intolerance		
		O The cancer did not progress while the patient was on pembrolizumab		
an	Ο	Documentation confirming that the patient has been informed and acknowledges that funded treatment with nivolumab will not be continued if their disease progresses		
	isites (required after 4 months tick boxes where appropriate) ibed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ al.		
		O Patient's disease has had a complete response to treatment		
		or O Patient's disease has had a partial response to treatment		
		or O Patient has stable disease		
	and	O Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period		
O The treatment remains clinically appropriate and the patient is benefitting from the treatment		\sim		
or		O Patient has previously discontinued treatment with nivolumab for reasons other than severe toxicity or disease progression		
	and	O Patient has signs of disease progression		
	and	O Disease has not progressed during previous treatment with nivolumab		

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.

PRESCRIBI	ER		PATIENT:
Name:			
Ward:			NHI:
Nivoluma	1 b - c	ontinu	ed
Re-assessr Prerequisit	ment i tes (ti	require ck bo	re than 24 months on treatment d after 4 months es where appropriate)
	rescri ospita		, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and	Э г	Patient	has been on treatment for more than 24 months
	or		O Patient's disease has had a partial response to treatment
		and (and	 Response to treatment in target lesions has been determined by comparable radiologic or clinical assessment following the most recent treatment period The treatment remains clinically appropriate and the patient is benefitting from the treatment
	or	(and	 Patient has previously discontinued treatment with nivolumab for reasons other than severe toxicity or disease progression Patient has signs of disease progression
		and (Disease has not progressed during previous treatment with nivolumab

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:
Pembrolizumab	

Re-a	issess	N – unresectable or metastatic melanoma sment required after 4 months ites (tick boxes where appropriate)
(and		Prescribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	(and	O Patient has metastatic or unresectable melanoma (excluding uveal) stage III or IV
	and (O Baseline measurement of overall tumour burden is documented clinically and radiologically
	and (O The patient has ECOG performance score of 0-2
		O Patient has not received funded nivolumab
		O Patient has received an initial Special Authority approval for nivolumab and has discontinued nivolumab within 12 weeks of starting treatment due to intolerance
		O The cancer did not progress while the patient was on nivolumab
	and (O Documentation confirming that the patient has been informed and acknowledges that funded treatment with pembrolizumab will not be continued if their disease progresses
	equisi O F	sment required after 4 months ites (tick boxes where appropriate) Prescribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
unu		
		O Patient's disease has had a complete response to treatment
		O Patient's disease has had a partial response to treatment
		and O Patient has stable disease
		Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period
		and O The treatment remains clinically appropriate and the patient is benefitting from the treatment
or		
		O Patient has previously discontinued treatment with pembrolizumab for reasons other than severe toxicity or disease progression and
		O Patient has signs of disease progression and

Use this checklist to determine if a patient meets the restrictions for funding in the Schedule. For community funding, see the Special Authority Criteria.	e hospital setting . For more details, refer to Section H of the Pharmaceutical
PRESCRIBER	PATIENT:

Name:	 Name:
Ward:	 NHI:

Pembrolizumab - continued

Re-a	ssess	ment	require	resectable or metastatic melanoma, more than 24 months on treatment ad after 4 months tes where appropriate)
(and		rescr lospit		y, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
	(and	F C	Patient	has been on treatment for more than 24 months
		or	and	 O Patient's disease has had a complete response to treatment O Patient's disease has had a partial response to treatment O Patient has stable disease O Response to treatment in target lesions has been determined by comparable radiologic or clinical assessment following the most recent treatment period O The treatment remains clinically appropriate and the patient is benefitting from the treatment
		U	and and	 Patient has previously discontinued treatment with pembrolizumab for reasons other than severe toxicity or disease progression Patient has signs of disease progression Disease has not progressed during previous treatment with pembrolizumab

I confirm that the above details are correct
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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:				
Pembrolizumab - continued					
INITIATION – non-small cell lung cancer first-line monotherapy Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)					
O Prescribed by, or recommended by a medical oncologist or any relevance with a protocol or guideline that has been endorsed by the and	vant practitioner on the recommendation of a medical oncologist, or in he Health NZ Hospital.				
O Patient has locally advanced or metastatic, unresectable, non-	small cell lung cancer				
	Patient has not had chemotherapy for their disease in the palliative setting				
	Patient has not received prior funded treatment with an immune checkpoint inhibitor for NSCLC				
O For patients with non-squamous histology there is documentat EGFR or ALK tyrosine kinase unless not possible to ascertain	ion confirming that the disease does not express activating mutations of				
and O Pembrolizumab to be used as monotherapy and					
O There is documentation confirming the disease expresse validated test unless not possible to ascertain	es PD-L1 at a level greater than or equal to 50% as determined by a				
O There is documentation confirming the disease ex by a validated test unless not possible to ascertain	presses PD-L1 at a level greater than or equal to 1% as determined				
	interest of the patient based on clinician assessment				
and Patient has an ECOG 0-2					
O Pembrolizumab to be used at a maximum dose of 200 mg eve	ry three weeks (or equivalent) for a maximum of 16 weeks				
Baseline measurement of overall tumour burden is documente	d clinically and radiologically				

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:
Pembrolizumab - continued	
CONTINUATION – non-small cell lung cancer first-line monotherapy Re-assessment required after 4 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a medical oncologist or any re accordance with a protocol or guideline that has been endorsed b	elevant practitioner on the recommendation of a medical oncologist, or in by the Health NZ Hospital.
O Patient's disease has had a complete response to tree or O Patient's disease has had a partial response to treatmon or O Patient has stable disease	
and O Response to treatment in target lesions has been determine treatment period and O No evidence of disease progression and	ed by comparable radiologic assessment following the most recent
 The treatment remains clinically appropriate and patient is land Pembrolizumab to be used at a maximum dose of 200 mg and Treatment with pembrolizumab to cease after a total duration every 3 weeks) 	
accordance with a protocol or guideline that has been endorsed to and Patient has locally advanced or metastatic, unresectable, n and The patient has not had chemotherapy for their disease in t and Patient has not received prior funded treatment with an imm and For patients with non-squamous histology there is documer EGFR or ALK tyrosine kinase unless not possible to ascert and Pembrolizumab to be used in combination with platinum-ba and Patient has an ECOG 0-2 and	elevant practitioner on the recommendation of a medical oncologist, or in by the Health NZ Hospital. on-small cell lung cancer he palliative setting nune checkpoint inhibitor for NSCLC ntation confirming that the disease does not express activating mutations of ain sed chemotherapy
and O Baseline measurement of overall tumour burden is docume	every three weeks (or equivalent) for a maximum of 16 weeks

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:
Pembro	lizur	nab - continued		
		N – non-small cell lung can required after 4 months	cer first-line combination ther	гару
		tick boxes where appropriate	·)	
and			a medical oncologist or any releasion of the second s	evant practitioner on the recommendation of a medical oncologist, or in the Health NZ Hospital.
	or	0	nad a complete response to treat	
	or	O Patient has stable dise	nad a partial response to treatme	
and	0	Response to treatment in tar treatment period	get lesions has been determined	by comparable radiologic assessment following the most recent
	Ο	No evidence of disease prog	ression	
and	Ο	The treatment remains clinic	ally appropriate and patient is be	enefitting from treatment
	Ο	Pembrolizumab to be used a	t a maximum dose of 200 mg ev	very three weeks (or equivalent)
and		Treatment with pembrolizuma every 3 weeks)	ab to cease after a total duration	of 24 months from commencement (or equivalent of 35 cycles dosed

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:

Durvalumab

_				
			Non-small cell lung cancer t required after 3 months	
Prer	equi	sites	(tick boxes where appropriate)	
and	0	Preso Hosp	cribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.	
	and	O	Patient has histologically or cytologically documented stage III, locally advanced, unresectable non-small cell lung cancer (NSCLC)	
	and	Ο	Patient has received two or more cycles of platinum-based chemotherapy concurrently with definitive radiation therapy	
		Ο	Patient has no disease progression following the second or subsequent cycle of platinum-based chemotherapy with definitive radiation therapy treatment	
	and	Ο	Patient has a ECOG performance status of 0 or 1	
		Ο	Patient has completed last radiation dose within 8 weeks of starting treatment with durvalumab	
	and O Patient must not have received prior PD-1 or PD-L1 inhibitor therapy for this condition and			
	O Durvalumab is to be used at a maximum dose of no greater than 10 mg/kg every 2 weeks or			
			O Durvalumab is to be used at a flat dose of 1500 mg every 4 weeks	
	and	O	Treatment with durvalumab to cease upon signs of disease progression	
CONTINUATION – Non-small cell lung cancer Re-assessment required after 3 months				
Prerequisites (tick boxes where appropriate)				
and	0		cribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ	
and		~		

and	0	The treatment remains clinically appropriate and the patient is benefitting from treatment
		m O Durvalumab is to be used at a maximum dose of no greater than 10 mg/kg every 2 weeks
	or	O Durvalumab is to be used at a flat dose of 1500 mg every 4 weeks
and and	0	Treatment with durvalumab to cease upon signs of disease progression
ana	Ο	Total continuous treatment duration must not exceed 12 months

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.

PRES	CRIBER	PATIENT:
Name	:	Name:
Ward:		
Atez	olizuma	ıb
INITI Re-a	ATION – r ssessmen equisites O Preso	hon-small cell lung cancer second line monotherapy th required after 4 months (tick boxes where appropriate) cribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in redance with a protocol or guideline that has been endorsed by the Health NZ Hospital. Patient has locally advanced or metastatic non-small cell lung cancer Patient has not received prior funded treatment with an immune checkpoint inhibitor for NSCLC For patients with non-squamous histology there is documentation confirming that the disease does not express activating mutations of EGFR or ALK tyrosine kinase unless not possible to ascertain Patient has an ECOG 0-2 Patient has documented disease progression following treatment with at least two cycles of platinum-based chemotherapy Atezolizumab is to be used as monotherapy at a dose of 1200 mg every three weeks (or equivalent) for a maximum of 16 weeks
		Baseline measurement of overall tumour burden is documented clinically and radiologically ON – non-small cell lung cancer second line monotherapy t required after 4 mention
		trequired after 4 months (tick boxes where appropriate)
(and		cribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in rdance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	or or	 Patient's disease has had a complete response to treatment Patient's disease has had a partial response to treatment Patient has stable disease
	and and and and and	Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period No evidence of disease progression The treatment remains clinically appropriate and patient is benefitting from treatment Atezolizumab to be used at a maximum dose of 1200 mg every three weeks (or equivalent)
	and O	Treatment with atezolizumab to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every

I confirm that the above details are correct:

3 weeks)

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	PATIENT:				
Name:	Name:				
Ward:	NHI:				
Everolimus					
INITIATION Re-assessment required after 3 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a neurologist or oncologist, or in Health NZ Hospital.	accordance with a protocol or guideline that has been endorsed by the				
O Patient has tuberous sclerosis and O Patient has progressively enlarging sub-ependymal giant cell a					
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a neurologist or oncologist, or in Health NZ Hospital.	accordance with a protocol or guideline that has been endorsed by the				
Documented evidence of SEGA reduction or stabilisation by M and The treatment remains appropriate and the patient is benefiting and Everolimus to be discontinued at progression of SEGAs					

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.	

SCRIBER	PATIENT:
ne:	Name:
d:	NHI:
blimus	
TIATION	
requisites (tick box where appropriate)	
O For rescue therapy for an organ transplant recipient e: Rescue therapy defined as unresponsive to calcineurin inhibi atment due to any of the following:	itor treatment as defined by refractory rejection; or intolerant to calcineurin inhibitor
GFR < 30 ml/min; or	
Rapidly progressive transplant vasculopathy; or	
Rapidly progressive obstructive bronchiolitis; or	
HUS or TTP; or	
Leukoencepthalopathy; or	
Significant malignant disease	
 Patient has severe non-malignant lymphovascular n and O Malformations are not adequately controlled b or O Malformations are widespread/extensive and or O Sirolimus is to be used to reduce malformation and O Patient is being treated by a specialist lymphovascular O Patient has measurable disease as defined by REC 	by sclerotherapy and surgery sclerotherapy and surgery are not considered clinically appropriate on prior to consideration of surgery ular malformation multi-disciplinary team
NTINUATION – severe non-malignant lymphovascular malfo assessment required after 12 months arequisites (tick boxes where appropriate)	ormations*
O Patient's disease has had either a complete re according to RECIST version 1.1 (see Note)	esponse or a partial response to treatment, or patient has stable disease
or or	esponse or a partial response to treatment, or patient has stable disease
or O Patient's disease has stabilised or responded	

Signed: Date:	
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Use this checklist to determine if a patient meets the restrictions for fund Schedule. For community funding, see the Special Authority Criteria.	ling in the hospital setting . For more details, refer to Section H of the Pharmaceutica
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Sirolimus - continued	
	sclerosis complex*
Health NZ Hospital.	
O Patient has tuberous sclerosis complex*	
O Evidence of renal angiomyolipoma(s) measuring 3 cm	or greater and that have shown interval growth
CONTINUATION – renal angiomyolipoma(s) associated with tuber Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	rous sclerosis complex*
O Documented evidence of renal angiomyolipoma reduct	tion or stability by magnetic resonance imaging (MRI) or ultrasound
O Demonstrated stabilisation or improvement in renal fur	nction
and O The patient has not experienced angiomyolipoma haer and	morrhage or significant adverse effects to sirolimus treatment
O The treatment remains appropriate and the patient is b	penefitting from treatment
Note: Indications marked with * are unapproved indications	
INITIATION – refractory seizures associated with tuberous sclero Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a neurologist, or in accorr Hospital.	sis complex* rdance with a protocol or guideline that has been endorsed by the Health NZ
and O Patient has epilepsy with a background of documented and	d tuberous sclerosis complex*
O Vigabatrin has been trialled and has not at and O Seizures are not adequately controlled by,	or the patient has experienced unacceptable side effects from, optimal : sodium valproate, topiramate, levetiracetam, carbamazepine, lamotrigine,
or O Vigabatrin is contraindicated and O Seizures are not adequately controlled by,	or the patient has experienced unacceptable side effects from, optimal ng: sodium valproate, topiramate, levetiracetam, carbamazepine, lamotrigine,
benefit from mTOR inhibitor treatment prior to surgery	inappropriate for this patient, or the patient has been assessed and would n sodium, sodium valproate, and topiramate. Those who can father children are not

 \bigcirc

and

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	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Sirolimus - continued			
CONTINUATION – refractory seizures associated with tuberous sclerosis	s complex*		
Re-assessment required after 12 months			

Prerequisites (tick box where appropriate)

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

Demonstrated significant and sustained improvement in seizure rate (e.g. 50% reduction in seizure frequency) or severity and/or patient quality of life compared with baseline prior to starting sirolimus treatment Note: Indications marked with * are unapproved indications

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:
Bacillus calmette-guerin (BCG)	
INITIATION Prerequisites (tick box where appropriate)	
O For use in bladder cancer	

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:

Upadacitinib

Re-a	INITIATION – Rheumatoid Arthritis (patients previously treated with adalimumab or etanercept) Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)					
and		Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ dospital.				
	and	0	The p	patient has had an initial Special Authority approval for adalimumab and/or etanercept for rheumatoid arthritis		
		or	 O The patient has experienced intolerable side effects from adalimumab and/or etanercept O 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	or	O The patient is seronegative for both anti-cyclic citrullinated peptide (CCP) antibodies and rheumatoid factor			
			O The patient has been started on rituximab for rheumatoid arthritis in a Health NZ Hospital and O The patient has experienced intolerable side effects from rituximab or O			
				O 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

()

or

Prerequisites (tick boxes where appropriate)

C	Prescribed by, or recommended by a rheu	matologist, or in	n accordance with a	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

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

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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:
Baricitinib	
INITIATION – moderate to severe COVID-19* Re-assessment required after 14 days Prerequisites (tick boxes where appropriate)	
O Patient has confirmed (or probable) COVID-19*	
and Oxygen saturation of < 92% on room air, or requiring supplement and O Patient is receiving adjunct systemic corticosteroids, or system	
and O Baricitinib is to be administered at doses no greater than 4 mg and	

 \bigcirc Baricitinib is not to be administered in combination with tocilizumab

Note: Indications marked with * are unapproved indications.

Respiratory System and Allergies

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.

PRES	CRIBE	ĒR	PATIENT:
Name	:		Name:
Ward:			NHI:
Icatil	bant		
Re-a	equisit	nent required after 12 months tes (tick boxes where appropriate)	nt specialist, or in accordance with a protocol or guideline that has been
	 Supply for anticipated emergency treatment of laryngeal/oro-pharyngeal or severe abdominal attacks of acute hereditary angioedema (HAE) for patients with confirmed diagnosis of C1-esterase inhibitor deficiency The patient has undergone product training and has agreed upon an action plan for self-administration 		
			oon an action plan for self-administration

CONTINUATION

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

O The treatment remains appropriate and the patient is benefiting from treatment

or

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	PATIENT:
Name:	Name:
Ward:	NHI:
Adrenaline	
INITIATION – anaphylaxis Prerequisites (tick boxes where appropriate)	
O Patient has experienced a previous anaphylactic reaction which	ch has resulted in presentation to a hospital or emergency department

Patient has been assessed to be at significant risk of anaphylaxis by a relevant practitioner

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:
Bee venom	
INITIATION Prerequisites (tick boxes where appropriate)	
ARAST or skin test positive	
O Patient has had severe generalised reaction to the sensitis	sing agent

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.

PRES	SCRIBER		PATIENT:	
Name:			Name:	
Ward:	:		NHI:	
Раре	er wasp	venom		
	ATION equisites	(tick boxes where appropriate)		
	and	RAST or skin test positive		
		Patient has had severe generalised reaction to the sensitising	agent	

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.

PRESC	CRIBER	PATIENT:
Name:		Name:
Ward:		NHI:
Yellow	v jacket wasp venom	
INITIA [®] Prerec	TION quisites (tick boxes where appropriate)	
	O RAST or skin test positive	
	O Patient has had severe generalised reaction to the sensitising	agent

Form	RS1518
July 20	24

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:	

Long-acting muscarinic antagonists with long-acting beta-adrenoceptor agonists

	ATION sessment required after 2 years quisites (tick boxes where appropriate)
	 Patient has been stabilised on a long acting muscarinic antagonist and The prescriber considers that the patient would receive additional benefit from switching to a combination product
Re-as	FINUATION esessment required after 2 years quisites (tick boxes where appropriate)
	Patient is compliant with the medication and Patient has experienced improved COPD symptom control (prescriber determined)

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:

Fluticasone furoate with umeclidinium and vilanterol

and	possib	
	and	O Patient is currently receiving an inhaled corticosteroid with long acting beta-2 agonist (ICS/LABA) or a long acting muscarinic antagonist with long acting beta-2 agonist (LAMA/LABA)
	anu	Clinical criteria:
		O Patient has a COPD Assessment Test (CAT) score greater than 10
		or O Patient has had 2 or more exacerbations in the previous 12 months
		O Patient has had one exacerbation requiring hospitalisation in the previous 12 months
		O Patient has had an eosinophil count greater than or equal to 0.3 × 10 [°] 9 cells/L in the previous 12 months
0	r	

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:

Pirfenidone

INITIATION - idiopathic pulmonary fibrosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Image: the preservibed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and Image: the preservibed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and Patient has been diagnosed with idiopathic pulmonary fibrosis by a multidisciplinary team including a radiologist and Pirfenidone is to be discontinued at disease progression (See Notes) and Pirfenidone is not to be used in combination with subsidised nintedanib or Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance or Patient has previously received nintedanib, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with nintedanib) CONTINUATION - idiopathic pulmonary fibrosis Re-assessment required after 12 months Prerequisite (ick boxes where appropriate) or Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and Prescribed by, or recommended by a resp							
Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. Patient has been diagnosed with idiopathic pulmonary fibrosis by a multidisciplinary team including a radiologist Proceed vital capacity is between 50% and 90% predicted Pirfenidone is to be discontinued at disease progression (See Notes) Pirfenidone is not to be used in combination with subsidised nintedanib or Patient has previously received nintedanib, but discontinued nintedanib or Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance or Patient has previously received nintedanib, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with nintedanib)	Re-assessment required after 12 months						
NZ Hospital. And Patient has been diagnosed with idiopathic pulmonary fibrosis by a multidisciplinary team including a radiologist and Proceed vital capacity is between 50% and 90% predicted and Pirfenidone is to be discontinued at disease progression (See Notes) and Pirfenidone is not to be used in combination with subsidised nintedanib and Pirfenidone is not to be used in combination with subsidised nintedanib and Patient has previously received treatment with nintedanib or Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance or Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance or Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance or Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance or Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance or Patient has previously received nintedanib, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with nintedanib) CONTINUATION – idiopathic pulmonary fibrosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and Pirfenidone is not to be used in combination with subsidised nintedanib and Pirfenidone is not to be used in combination with subsidised nintedanib	Prerequisites (tick boxes where appropriate)						
and Forced vital capacity is between 50% and 90% predicted and Pirfenidone is to be discontinued at disease progression (See Notes) and Pirfenidone is not to be used in combination with subsidised nintedanib and Pirfenidone is not to be used in combination with subsidised nintedanib or Patient has not previously received treatment with nintedanib or Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance or Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance or Patient has previously received nintedanib, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with nintedanib) CONTINUATION - idiopathic pulmonary fibrosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and Pirfenidone is not to be used in combination with subsidised nintedanib	NZ Hospital.						
CONTINUATION - idiopathic pulmonary fibrosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.							
and Pirfenidone is not to be used in combination with subsidised nintedanib and Or Or Patient has not previously received treatment with nintedanib or Or Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance or Or Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance or Or Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance or Patient has previously received nintedanib, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with nintedanib) CONTINUATION – idiopathic pulmonary fibrosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Or Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and Or Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment and Or Pirfenidone is not to be used in combination with subsidised nintedanib	O Forced vital capacity is between 50% and 90% predicted						
and O The patient has not previously received treatment with nintedanib or O Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance or O Patient has previously received nintedanib, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with nintedanib) CONTINUATION – idiopathic pulmonary fibrosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment and O Pirfenidone is not to be used in combination with subsidised nintedanib							
 or Or Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance or Or Patient has previously received nintedanib, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with nintedanib) CONTINUATION - idiopathic pulmonary fibrosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Or Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and Or Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment and Or Pirfenidone is not to be used in combination with subsidised nintedanib 							
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or more decline in predicted FVC within any 12 month period since starting treatment with nintedanib) CONTINUATION - idiopathic pulmonary fibrosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment and O Pirfenidone is not to be used in combination with subsidised nintedanib	O Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance						
Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment and O Pirfenidone is not to be used in combination with subsidised nintedanib and O D D D D D D D D D D D D D D D D D D							
Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment and O Pirfenidone is not to be used in combination with subsidised nintedanib and O D D D D D D D D D D D D D D D D D D							
Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment and Pirfenidone is not to be used in combination with subsidised nintedanib	Re-assessment required after 12 months						
and NZ Hospital.	Prerequisites (tick boxes where appropriate)						
and O Pirfenidone is not to be used in combination with subsidised nintedanib and O	NZ Hospital.						
O Pirfenidone is not to be used in combination with subsidised nintedanib and							
O Pirfenidone is to be discontinued at disease progression (See Note)	O Pirfenidone is not to be used in combination with subsidised nintedanib						
	O Pirfenidone is to be discontinued at disease progression (See Note)						

Note: disease progression is defined as a decline in percent predicted FVC of 10% or more within any 12 month period.

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:

Nintedanib

Re-as	sessi	I – idiopathic pulmonary fibrosis nent required after 12 months tes (tick boxes where appropriate)				
and		Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health IZ Hospital.				
	(and	D Patient has been diagnosed with idiopathic pulmonary fibrosis by a multidisciplinary team including a radiologist				
	and (C Forced vital capacity is between 50% and 90% predicted				
	and	O Nintedanib is to be discontinued at disease progression (See Note)				
	(and	O Nintedanib is not to be used in combination with subsidised pirfenidone				
		O The patient has not previously received treatment with pirfenidone				
		O Patient has previously received pirfenidone, but discontinued pirfenidone within 12 weeks due to intolerance or				
		O Patient has previously received pirfenidone, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with pirfenidone)				
Re-as	CONTINUATION – idiopathic pulmonary fibrosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)					
and		rescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health Z Hospital.				
	(and	C Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment				
	and	O Nintedanib is not to be used in combination with subsidised pirfenidone				
	(O Nintedanib is to be discontinued at disease progression (See Note)				

Note: disease progression is defined as a decline in percent predicted FVC of 10% or more within any 12 month period.

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:
Ivaca	ftor			
INITIA Prerect	quisit	t es (resc	ribed	boxes where appropriate) by, or recommended by a respiratory specialist or paediatrician, or in accordance with a protocol or guideline that has been by the Health NZ Hospital.
	and)	Patie	ent has been diagnosed with cystic fibrosis
		or	0	Patient must have G551D mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene on at least 1 allele
		01	0	Patient must have other gating (class III) mutation (G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N and S549R) in the CFTR gene on at least 1 allele
	and			ents must have a sweat chloride value of at least 60 mmol/L by quantitative pilocarpine iontophoresis or by Macroduct sweat ction system
and O Patient must not have an acute upper or lower respiratory infection, pulmonary			Treat	tment with ivacaftor must be given concomitantly with standard therapy for this condition
				ent must not have an acute upper or lower respiratory infection, pulmonary exacerbation, or changes in therapy (including iotics) for pulmonary disease in the last 4 weeks prior to commencing treatment with ivacaftor
	and (and	C	The c	dose of ivacaftor will not exceed one tablet or one sachet twice daily
)	Appli	icant has experience and expertise in the management of cystic fibrosis

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:		

Elexacaftor with tezacaftor, ivacaftor and ivacaftor

INITIATION

equis	ites	tick boxes where appropriate)	
and	0	Patient has been diagnosed with cystic fibrosis	
and	0	Patient is 6 years of age or older	
		O Patient has two cystic fibrosis-causing mutations in the cystic fibrosis transmembrane regulator (CFTR) gene (one from each parental allele)	
	or	O Patient has a sweat chloride value of at least 60 mmol/L by quantitative pilocarpine iontophoresis or by Macroduct sweat collection system	
and	_		
O Patient has a heterozygous or homozygous F508del mutation		O Patient has a heterozygous or homozygous F508del mutation	
or O Patient has a G551D mutation or other mutation responsive in vitro to elexacaftor/tezacaftor/ivacaftor (see note a)			
and O The treatment must be the sole funded CFTR modulator therapy for this condition			
and		Treatment with elexacaftor/tezacaftor/ivacaftor must be given concomitantly with standard therapy for this condition	
:			
		ations are listed in the Food and Drug Administration (FDA) Trikafta prescribing information accessdata.fda.gov/drugsatfda_docs/label/2021/212273s004lbl.pdf	

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:		

Dornase alfa

INITIATION – cystic fibrosis Re-assessment required after 12 months			
Prerequisites (tick boxes where appropriate)			
O Prescribed by, or recommended by a respiratory physician or paediatrician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
O Patient has a confirmed diagnosis of cystic fibrosis			
O Patient has previously undergone a trial with, or is currently being treated with, hypertonic saline and			
O Patient has required one or more hospital inpatient respiratory admissions in the previous 12 month period or			
O Patient has had 3 exacerbations due to CF, requiring oral or intravenous (IV) antibiotics in in the previous 12 month period or			
O Patient has had 1 exacerbation due to CF, requiring oral or IV antibiotics in the previous 12 month period and a Brasfield score of < 22/25			
or O Patient has a diagnosis of allergic bronchopulmonary aspergillosis (ABPA)			
CONTINUATION - cystic fibrosis Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a respiratory physician or paediatrician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O The treatment remains appropriate and the patient continues to benefit from treatment			
INITIATION – significant mucus production Re-assessment required after 4 weeks Prerequisites (tick boxes where appropriate)			
O Patient is an in-patient and O The mucus production cannot be cleared by first line chest techniques			
INITIATION – pleural emphyema Re-assessment required after 3 days Prerequisites (tick boxes where appropriate)			
O Patient is an in-patient and O Patient diagnoses with pleural emphyema			

Sensory Organs

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:		

Dexamethasone

INITIATION – Diabetic macular oedema
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)
O Prescribed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
O Patients have diabetic macular oedema with pseudophakic lens
O Patient has reduced visual acuity of between 6/9 – 6/48 with functional awareness of reduction in vision
O Patient's disease has progressed despite 3 injections with bevacizumab or
O Patient is unsuitable or contraindicated to treatment with anti-VEGF agents
Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year
CONTINUATION – Diabetic macular oedema Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)
Prescribed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
O Patient's vision is stable or has improved (prescriber determined)
O Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year
INITIATION – Women of child bearing age with diabetic macular oedema
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)
O Prescribed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
and
O Patients have diabetic macular oedema and
O Patient has reduced visual acuity of between 6/9 – 6/48 with functional awareness of reduction in vision and
O Patient is of child bearing potential and has not yet completed a family and
O Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year

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.

PRES	CRIB	ER		PATIENT:
Name):			Name:
Ward:				NHI:
Dexa	meth	has	sone - continued	
Re-a	ssessr	mer	DN – Women of child bearing age with diabetic macular oed tt required after 12 months (tick boxes where appropriate)	lema
(and		reso losp		ance with a protocol or guideline that has been endorsed by the Health NZ
		С	Patient's vision is stable or has improved (prescriber determine	ed)
	and	С	Patient is of child bearing potential and has not yet completed	a family
	and (С	Dexamethasone implants are to be administered not more free of 3 implants per eye per year	quently than once every 4 months into each eye, and up to a maximum

Various

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:		

Deferasirox

	sses	I nent required after 2 years t es (tick boxes where approp	iate)	
(and	O Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
	and		gnosed with chronic iron overload due to congenital inherited anaemia at a daily dose not exceeding 40 mg/kg/day	
		or have proven ineffect or O Treatment with defect or O Treatment with defect or O Treatment with defect	timum tolerated doses of deferiprone monotherapy or deferiprone and desferrioxamine combination therapy tive as measured by serum ferritin levels, liver or cardiac MRI T2* eriprone has resulted in severe persistent vomiting or diarrhoea eriprone has resulted in arthritis eriprone is contraindicated due to a history of agranulocytosis (defined as an absolute neutrophil count s per μL) or recurrent episodes (greater than 2 episodes) of moderate neutropenia (ANC 0.5 - 1.0 cells per	
CONTINUATION Re-assessment required after 2 years Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ				
and		ospital.		
	or	parameters namely serur D For subsequent renewals	ving 2 years of therapy, the treatment has been tolerated and has resulted in clinical improvement in all three n ferritin, cardiac MRI T2* and liver MRI T2* levels , the treatment has been tolerated and has resulted in clinical stability or continued improvement in all three n ferritin, cardiac MRI T2* and liver MRI T2* levels.	

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:	
Deferiprone		
INITIATION		

Prerequisites (tick box where appropriate)

O Patient has been diagnosed with chronic iron overload due to congenital inherited anaemia or acquired red cell aplasia

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:		
Povidone-iodine - Vaginal tab 200 mg			
INITIATION Prerequisites (tick box where appropriate)			
O Rectal administration pre-prostate biopsy			

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:	
Chlorhexidine with cetrimide		
INITIATION Re-assessment required after 3 months Prerequisites (tick boxes where appropriate)	ace area (BSA)	
O For use in the perioperative preparation and cleansing of large burn areas requiring debridement/skin grafting and		
The use of 30 ml ampoules is impractical due to the size of the	e area to be covered	

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

O The treatment remains appropriate for the patient and the patient is benefiting from the treatment

Special Foods

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:		

Carbohydrate

INITIATION – Use as an additive Prerequisites (tick boxes where appropriate)				
	0	Cystic fibrosis		
or	Ο	Chronic kidney disease		
or	Ο	Cancer in children		
or	Ο	Cancers affecting alimentary tract where there are malabsorption problems in patients over the age of 20 years		
or	Ο	Faltering growth in an infant/child		
or	Ο	Bronchopulmonary dysplasia		
or	Ο	Premature and post premature infant		
or	0	Inborn errors of metabolism		
		Use as a module		

Prerequisites (tick box where appropriate)

O For use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

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.

PRES	SCRI	BER	ER PATIENT:	
Name	:		Name:	
Ward			NHI:	
Fat				
			I – Use as an additive tes (tick boxes where appropriate)	
		0	O Patient has inborn errors of metabolism	
	or	0	O Faltering growth in an infant/child	
	or	Ο	O Bronchopulmonary dysplasia	
	or	Ο	C Fat malabsorption	
	or	Ο	O Lymphangiectasia	
	or	Ο	O Short bowel syndrome	
	or	Ο	O Infants with necrotising enterocolitis	
	or	Ο	O Biliary atresia	
	or	Ο	O For use in a ketogenic diet	
	or	Ο	Chyle leak	
	or	Ο	O Ascites	
	or	Ο	O Patient has increased energy requirements, and for whom dietary measures have not been successful	

INITIATION – Use as a module

Prerequisites (tick box where appropriate)

O For use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk. Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

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	PATIENT:
Name:	Name:
Ward:	NHI:
Protein	
INITIATION – Use as an additive Prerequisites (tick boxes where appropriate)	
or O High protein needs	
NITIATION – Use as a module	

Prerequisites (tick box where appropriate)

O For use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk. Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

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:			
Carbohydrate and fat supplement				

Carbonydrate and fat supplement

t es (tick b	poxes where appropriate)	
)	Infan	t or child aged four years or under	
or	Ο	Cystic fibrosis	
	Ο	Cancer in children	
	Ο	Faltering growth	
	Ο	Bronchopulmonary dysplasia	
	0	Premature and post premature infants	
	ies (or o	Infant or child aged four years or under O Cystic fibrosis O Cystic fibrosis O Cancer in children O Faltering growth O Bronchopulmonary dysplasia

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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.

PRES	SCRIE	BER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Meta	boli	ic P	roducts	
INITI Prer			(tick boxes where appropriate)	
		Ο	For the dietary management of inherited metabolic disease	
O Patient has adrenoleukodystrophy				
	or	0	For use as a supplement to the Ketogenic diet in patients diag	nosed with epilepsy

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:

Diabetic Products

INITI. Prere			(tick boxes where appropriate)
ĺ		0	For patients with type I or type II diabetes suffering weight loss and malnutrition that requires nutritional support
	or	Ο	For patients with pancreatic insufficiency
	or	Ο	For patients who have, or are expected to, eat little or nothing for 5 days
	or	Ο	For patients who have a poor absorptive capacity and/or high nutrient losses and/or increased nutritional needs from causes such as catabolism
	or	0	For use pre- and post-surgery
	or	Ο	For patients being tube-fed
	or	Ο	For tube-feeding as a transition from intravenous nutrition

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:	
Elemental and Semi-Elemental Products		

	Ο	Malabsorption	
or	Ο	Short bowel syndrome	
or	Ο	Enterocutaneous fistulas	
or	0	Eosinophilic enteritis (including oesophagitis)	
or	Ο	Inflammatory bowel disease	
or	0	Acute pancreatitis where standard feeds are not tolerated	
or	Ο	Patients with multiple food allergies requiring enteral feeding	

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:
Fat-modified feed	
INITIATION Prerequisites (tick boxes where appropriate) O Patient has metabolic disorders of fat metabolism or O Patient has a chyle leak or O Modified as a modular feed, made from at least one nutrient m Pharmaceutical Schedule, for adults	nodule and at least one further product listed in Section D of the

Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

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:
Hepatic Products	
INITIATION Prerequisites (tick box where appropriate)	
O For children (up to 18 years) who require a liver transplant	

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:
llink Oslavia Dradusta	

High Calorie Products

INITIAT Prereq		s (tick boxes where appropriate)
	Ο	Patient is fluid volume or rate restricted
0	Ο	Patient requires low electrolyte
	an	O Cystic fibrosis or O Increased nutritional requirements
		O Patient has substantially increased metabolic requirements

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.

PRESCR	IBEI	2		PATIENT:
Name:				Name:
Ward:				NHI:
High pr	ote	in en	teral feed	
INITIATI Prerequ			boxes where appropriate) patient has a high protein requirement	
an	id C	0	Patient has liver disease Patient is obese (BMI > 30) and is undergoing surgery	
	0		Patient is fluid restricted	

O Patient's needs cannot be more appropriately met using high calorie product

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:	

Extensively hydrolysed formula

INITIATION Prerequisites (tick boxes where appropriate) Cows' milk formula is inappropriate due to severe intolerance or allergy to its protein content and Soy milk formula has been reasonably trialled without resolution of symptoms or Soy milk formula is considered clinically inappropriate or contraindicated or () Severe malabsorption or Short bowel syndrome or Intractable diarrhoea or Biliary atresia or Cholestatic liver diseases causing malsorption or Cystic fibrosis or () Proven fat malabsorption or Severe intestinal motility disorders causing significant malabsorption or ()Intestinal failure or For step down from Amino Acid Formula Note: A reasonable trial is defined as a 2-4 week trial, or signs of an immediate IgE mediated allergic reaction. CONTINUATION

Prerequisites (tick boxes where appropriate)

 \bigcirc

and

An assessment as to whether the infant can be transitioned to a cows' milk protein or soy infant formula has been undertaken

The outcome of the assessment is that the infant continues to require an extensively hydrolysed infant formula

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:
Preterm formula	
INITIATION Prerequisites (tick box where appropriate)	
O For infants born before 33 weeks' gestation or weighing less than 1.	5 kg at birth

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:	
Paediatric oral/enteral feed 1 kcal/ml		
INITIATION – Fluid restricted or volume intolerance with faltering growth		

Prerequisites (tick boxes where appropriate)

or

and

The patient is fluid restricted or volume intolerant

The patient has increased nutritional requirements due to faltering growth ()

) Patient is under 18 months old and weighs less than 8kg

Note: 'Volume intolerant' patients are those who are unable to tolerate an adequate volume of infant formula to achieve expected growth rate. These patients should have first trialled appropriate clinical alternative treatments, such as concentrating, fortifying and adjusting the frequency of feeding.

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:	

Enteral liquid peptide formula

INITIATION Prerequisites (tick boxes where appropriate) () Patient has impaired gastrointestinal function and either cannot tolerate polymeric feeds, or polymeric feeds are unsuitable and () Severe malabsorption or Short bowel syndrome or Intractable diarrhoea or Biliary atresia or Cholestatic liver diseases causing malabsorption or Cystic fibrosis or Proven fat malabsorption or Severe intestinal motility disorders causing significant malabsorption or Intestinal failure or O The patient is currently receiving funded amino acid formula and The patient is to be trialled on, or transitioned to, an enteral liquid peptide formula and () A semi-elemental or partially hydrolysed powdered feed has been reasonably trialled and considered unsuitable or For step down from intravenous nutrition Note: A reasonable trial is defined as a 2-4 week trial. CONTINUATION Prerequisites (tick boxes where appropriate) An assessment as to whether the patient can be transitioned to a cows milk protein or soy infant formula or extensively hydrolysed formula has been undertaken

The outcome of the assessment is that the patient continues to require an enteral liquid peptide formula

I confirm that the above details are correct:

and

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:	

Amino acid formula

INITIATION Prerequisites (tick boxes where appropriate) Image: Constraint of the system of the syst

CONTINUATION

and

and

and

and

Prerequisites	(tick boxes	where	appropriate)	ĺ
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An assessment as to whether the infant can be transitioned to a cows' milk protein, soy, or extensively hydrolysed infant formula has been undertaken
 The outcome of the assessment is that the infant continues to require an amino acid infant formula

 \bigcirc Amino acid formula is required for a nutritional deficit

INITIATION – patients who are currently funded under RS1502 or SA1557

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

Patient has a valid initiation or renewal approval for extensively hydrolysed formula (RS1502)

Patient is unable to source funded Aptamil powder at this time

The approval only applies to funded dispensings of Neocate Gold and Neocate Syneo

Note: This criteria is short term funding to cover an out-of-stock situation on some extensively hydrolysed formula powder funded under Hospital Restriction RS1502. There is no continuation criteria under this criterion.

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	PATIENT:		
Name:	Name:		
Ward:	NHI:		
High fat formula			

INITIATION

Prerequisites (tick box where appropriate)

()For patients with intractable epilepsy, pyruvate dehydrogenase deficiency or glucose transported type-1 deficiency and other conditions requiring a ketogenic diet

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:	

Paediatric Products

ITIATIC erequi		(tick b	poxes where appropriate)
and	O	Chilc	I is aged one to ten years
	or	Ο	The child is being fed via a tube or a tube is to be inserted for the purposes of feeding
		Ο	Any condition causing malabsorption
	or	Ο	Faltering growth in an infant/child
	or	Ο	Increased nutritional requirements
	or	Ο	The child is being transitioned from TPN or tube feeding to oral feeding
	or	0	The child has eaten, or is expected to eat, little or nothing for 3 days
	\subseteq		

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:
Low electrolyte oral feed	
INITIATION Prerequisites (tick box where appropriate)	
O For children (up to 18 years) with acute or chronic kidney disease	

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:
Low electrolyte enteral feed 1.8 kcal/ml	
INITIATION Prerequisites (tick box where appropriate)	
O For patients with acute or chronic kidney disease	

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:
Low electrolyte oral feed	
INITIATION Prerequisites (tick box where appropriate)	
O For patients with acute or chronic kidney disease	

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:	
Preoperative carbohydrate feed 0.5 kcal/ml		

INITIATION

Prerequisites (tick box where appropriate)

O Maximum of 400 ml as part of an Enhanced Recovery After Surgery (ERAS) protocol 2 to 3 hours before major abdominal surgery

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:	
High arginine oral feed 1.4 kcal/ml		
INITIATION Prerequisites (tick box where appropriate)		
m O Three packs per day for 5 to 7 days prior to major gastrointestinal, h	ead or neck surgery	

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:
Standard Feeds	

INITIATION

F	or p	patients with malnutrition, defined as any of the following:
		O BMI < 18.5
	or	O Greater than 10% weight loss in the last 3-6 months
	or	O BMI < 20 with greater than 5% weight loss in the last 3-6 months
or		
C	\mathbf{C}	For patients who have, or are expected to, eat little or nothing for 5 days
or c		For patients who have a poor absorptive capacity and/or high nutrient losses and/or increased nutritional needs from causes such as catabolism
	\mathbf{C}	For use pre- and post-surgery
or		For patients being tube-fed
or)	For tube-feeding as a transition from intravenous nutrition
or	ſ	For any other condition that meets the community Special Authority criteria

Vaccines

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:	

Diphtheria, tetanus, pertussis and polio vaccine

	Ο	A single dose for children up to the age of 7 who have completed primary immunisation
or	0	A course of up to four vaccines is funded for catch up programmes for children (to the age of 10 years) to complete full primary immunisation
or	0	An additional four doses (as appropriate) are funded for (re-)immunisation for patients post HSCT, or chemotherapy; pre- or post splenectomy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens
or	Ο	Five doses will be funded for children requiring solid organ transplantation

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:

Diphtheria, tetanus, pertussis, polio, hepatitis B and haemophilus influenzae type B vaccine

NITIATION Prerequisites	s (tick boxes where appropriate)	
or O or O	Up to four doses for children up to and under the age of 10 for primary immunisation An additional four doses (as appropriate) are funded for (re-)immunisation for children up to and under the age of 10 who are patients post haematopoietic stem cell transplantation, or chemotherapy; pre or post splenectomy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens Up to five doses for children up to and under the age of 10 receiving solid organ transplantation	
Note: A course of up-to four vaccines is funded for catch up programmes for children (up to and under the age of 10 years) to complete full primary immunisation. Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes.		

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.

PRES	CRIBER		PATIENT:
Name	:		Name:
Ward:			NHI:
Baci	llus calı	mette-guerin vaccine	
INITIATION Prerequisites (tick boxes where appropriate)			
For infants at increased risk of tuberculosis defined as:			
	${ m O}$ Living in a house or family with a person with current or past history of TB		istory of TB
	and Having one or more household members or carers who within the last 5 years lived in a country with a rate of TB > or equal to 40 per 100,000 for 6 months or longer		the last 5 years lived in a country with a rate of TB $>$ or equal to 40 per
	and	During their first 5 years will be living 3 months or longer in a c	country with a rate of TB > or equal to 40 per 100,000

Note: A list of countries with high rates of TB are available at http://www.health.govt.nz/tuberculosis (Search for Downloads) or www.bcgatlas.org/index.php

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:

Diphtheria, tetanus and pertussis vaccine

INITIATION Prerequisites (tick boxes where appropriate) () A single dose for pregnant women in the second or third trimester of each pregnancy; or or A single dose for parents or primary caregivers of infants admitted to a Neonatal Intensive Care Unit or Specialist Care Baby Unit for more than 3 days, who had not been exposed to maternal vaccination at least 14 days prior to birth; or or A course of up to four doses is funded for children from age 7 up the age of 18 years inclusive to complete full primary immunisation or An additional four doses (as appropriate) are funded for (re-)immunisation for patients post haematopoietic stem cell transplantation or chemotherapy; pre or post splenectomy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens or A single dose for vaccination of patients aged from 65 years old or A single dose for vaccination of patients aged from 45 years old who have not had 4 previous tetanus doses or For vaccination of previously unimmunised or partially immunised patients or For revaccination following immunosuppression or For boosting of patients with tetanus-prone wounds

Note: Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes.

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.

PRES	SCRI	BER		PATIENT:
Name	e:			Name:
Ward				NHI:
Haer	nop	ohilu	s influenzae type B vaccine	
	sses	smen	t required after 1 dose (tick boxes where appropriate)	
	~	Ο	For primary vaccination in children	
	or An additional dose (as appropriate) is funded for (re-)immunisation for patients post haematopoietic stem cell transplantation, or chemotherapy; functional asplenic; pre or post splenectomy; pre- or post solid organ transplant, pre- or post cochlear implants, renal dialysis and other severely immunosuppressive regimens			
	or	0	For use in testing for primary immunodeficiency diseases, on t	he recommendation of an internal medicine physician or paediatrician

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:

Meningococcal (A, C, Y and W-135) conjugate vaccine

INITIATION Prerequisites (tick boxes where appropriate) () Up to three doses and a booster every five years for patients pre- and post splenectomy and for patients with HIV, complement deficiency (acquired or inherited), functional or anatomic asplenia or pre or post solid organ transplant or One dose for close contacts of meningococcal cases of any group or One dose for person who has previously had meningococcal disease of any group or A maximum of two doses for bone marrow transplant patients or A maximum of two doses for person pre and post-immunosuppression* or () Person is aged between 13 and 25 years, inclusive and \bigcirc One dose for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, or prisons or ()One dose for individuals who turn 13 years of age while living in boarding school hostels

Note: children under seven years of age require two doses 8 weeks apart, a booster dose three years after the primary series and then five yearly. *Immunosuppression due to steroid or other immunosuppressive therapy must be for a period of greater than 28 days.

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:

Meningococcal (A, C, Y and W-135) conjugate vaccine

INITIATION – Children under 12 months of age Prerequisites (tick boxes where appropriate)			
	_	Ο	A maximum of three doses (dependant on age at first dose) for patients pre- and post- splenectomy and for patients with functional or
	or		anatomic asplenia, HIV, complement deficiency (acquired or inherited), or pre- or post- solid organ transplant
	o r	Ο	A maximum of three doses (dependant on age at first dose) for close contacts of meningococcal cases of any group
	or	Ο	A maximum of three doses (dependant on age at first dose) for child who has previously had meningococcal disease of any group
	or	0	A maximum of three doses (dependant on age at first dose) for bone marrow transplant patients
	or	0	A maximum of three doses (dependant on age at first dose) for child pre- and post-immunosuppression*
	_		

Note: infants from 6 weeks to less than 6 months of age require a 2+1 schedule, infants from 6 months to less than 12 months of age require a 1+1 schedule. Refer to the Immunisation Handbook for recommended booster schedules with meningococcal ACWY vaccine. *Immunosuppression due to steroid or other immunosuppressive therapy must be for a period of greater than 28 days.

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:

Meningococcal C conjugate vaccine

INITIATION - Children under 12 months of age Prerequisites (tick boxes where appropriate) \bigcirc Up to three doses for patients pre- and post splenectomy and for patients with HIV, complement deficiency (acquired or inherited), functional or anatomic asplenia or pre or post solid organ transplant or Two doses for close contacts of meningococcal cases of any group or Two doses for child who has previously had meningococcal disease of any group or A maximum of two doses for bone marrow transplant patients or A maximum of two doses for child pre- and post-immunosuppression*

Note: children under 12 months of age require two doses 8 weeks apart. Refer to the Immunisation Handbook for recommended booster schedules with meningococcal ACWY vaccine. *Immunosuppression due to steroid or other immunosuppressive therapy must be for a period of greater than 28 days.

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:	
Pneumococcal (PCV10) conjugate vaccine		

Pneumococcal (PCV10) conjugate vaccine

INITIATION

Prerequisites (tick box where appropriate)

 $m O\,$ A primary course of three doses for previously unvaccinated individuals up to the age of 59 months inclusive

Note: Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes

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.			
PATIENT:			
Name:			
NHI:			
I (PCV13) conjugate vaccine			
nary course for previously unvaccinated children aged under 5 years equired after 3 doses k box where appropriate)			
ry course of three doses for previously unvaccinated children up to the age of 59 months inclusive			
h risk individuals who have received PCV10 equired after 2 doses k box where appropriate) es are funded for high risk individuals (over the age of 12 months and under 18 years) who have previously received two doses of the course of PCV10			
INITIATION – High risk children aged under 5 years Re-assessment required after 4 doses Prerequisites (tick boxes where appropriate) O Up to an additional four doses (as appropriate) are funded for the (re)immunisation of high-risk children aged under 5 years			
 On immunosuppressive therapy or radiation therapy, vaccinate when there is expected to be a sufficient immune response Primary immune deficiencies HIV infection Renal failure, or nephrotic syndrome Are immune-suppressed following organ transplantation (including haematopoietic stem cell transplant) Cochlear implants or intracranial shunts Cerebrospinal fluid leaks Receiving corticosteroid therapy for more than two weeks, and who are on an equivalent daily dosage of prednisone of 2 mg/kg per day or greater, or children who weigh more than 10 kg on a total daily dosage of 20 mg or greater Chronic pulmonary disease (including asthma treated with high-dose corticosteroid therapy) Pre term infants, born before 28 weeks gestation Cardiac disease, with cyanosis or failure Diabetes Down syndrome 			

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:		
Pneumococcal (PCV13) conjugate vaccine - continued			
INITIATION – High risk individuals 5 years and over Re-assessment required after 4 doses Prerequisites (tick box where appropriate) O Up to an additional four doses (as appropriate) are funded for the (red)	e-)immunisation of individuals 5 years and over with HIV, pre or post bost splenectomy; functional asplenia, pre- or post- solid organ transplant, ear implants, intracranial shunts, cerebrospinal fluid leaks or primary		
INITIATION – Testing for primary immunodeficiency diseases Prerequisites (tick box where appropriate) O For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician			
Note: Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes			

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:		
Pneumococcal (PPV23) polysaccharide vaccine			
INITIATION – High risk patients Re-assessment required after 3 doses Prerequisites (tick box where appropriate) O For patients with HIV, for patients post haematopoietic stem cell transplant, or chemotherapy; pre- or post-splenectomy; or with functional asplenia, pre- or post-solid organ transplant, renal dialysis, complement deficiency (acquired or inherited), cochlear implants, or primary			
immunodeficiency INITIATION – High risk children Re-assessment required after 2 doses Prerequisites (tick boxes where appropriate)			
O Patient is a child under 18 years for (re-)immunisation			
or O With primary immune deficiencies or O With HIV infection or O With renal failure, or nephrotic syndrome or O Who are immune-suppressed following organ transplan or O With cochlear implants or intracranial shunts or O With cerebrospinal fluid leaks or O	ks, and who are on an equivalent daily dosage of prednisone of 2 mg/kg kg on a total daily dosage of 20 mg or greater red with high-dose corticosteroid therapy)		

INITIATION – Testing for primary immunodeficiency diseases Prerequisites (tick box where appropriate)

O For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician

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:
Salmonella typhi vaccine	
INITIATION Prerequisites (tick box where appropriate)	
${igodoldoldoldoldoldoldoldoldoldoldoldoldol$	

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:		
Meningococcal B multicomponent vaccine			
INITIATION – Primary immunisation for children up to 12 months of age			
Re-assessment required after 3 doses Prerequisites (tick boxes where appropriate)			
O Three doses for children up to 12 months of age (inclusive) fo			
Up to three doses (dependent on age at first dose) for a catch (inclusive) for primary immunisation, from 1 March 2023 to 31	-up programme for children from 13 months to 59 months of age August 2025		
INITIATION – Person is one year of age or over Prerequisites (tick boxes where appropriate)			
O Up to two doses and a booster every five years for patients pr asplenia, HIV, complement deficiency (acquired or inherited),	e- and post-splenectomy and for patients with functional or anatomic or pre- or post-solid organ transplant		
O Up to two doses for close contacts of meningococcal cases o	f any group		
or O Up to two doses for person who has previously had meningoo	eoccal disease of any group		
O Up to two doses for bone marrow transplant patients			
or O Up to two doses for person pre- and post-immunosuppression)*		
INITIATION – Person is aged between 13 and 25 years (inclusive) Re-assessment required after 2 doses Prerequisites (tick boxes where appropriate)			
O Person is aged between 13 and 25 years (inclusive)			

O Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons

O Two doses for individuals who turn 13 years of age while living in boarding school hostels

Note: *Immunosuppression due to corticosteroid or other immunosuppressive therapy must be for a period of greater than 28 days.

or

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	e:			Name:
Ward	:			NHI:
Нера	atiti	s A y	vaccine	
INITIATION Prerequisites (tick boxes where appropriate)				
	or	Ο	Two vaccinations for use in transplant patients	
		Ο	Two vaccinations for use in children with chronic liver disease	
	or O		One dose of vaccine for close contacts of known hepatitis A ca	ases

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:

Hepatitis B recombinant vaccine

INITIATION Prerequisites (tick boxes where appropriate) () For household or sexual contacts of known acute hepatitis B patients or hepatitis B carriers or For children born to mothers who are hepatitis B surface antigen (HBsAg) positive or For children up to and under the age of 18 years inclusive who are considered not to have achieved a positive serology and require additional vaccination or require a primary course of vaccination or ()For HIV positive patients or For hepatitis C positive patients or For patients following non-consensual sexual intercourse or For patients following immunosuppression or () For solid organ transplant patients or For post-haematopoietic stem cell transplant (HSCT) patients or Following needle stick injury or For dialysis patients or ()For liver or kidney transplant patients

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:

Hepatitis B recombinant vaccine

INITIATION Prerequisites (tick boxes where appropriate) () For household or sexual contacts of known acute hepatitis B patients or hepatitis B carriers or For children born to mothers who are hepatitis B surface antigen (HBsAg) positive or For children up to and under the age of 18 years inclusive who are considered not to have achieved a positive serology and require additional vaccination or require a primary course of vaccination or ()For HIV positive patients or For hepatitis C positive patients or For patients following non-consensual sexual intercourse or For patients following immunosuppression or For solid organ transplant patients () or For post-haematopoietic stem cell transplant (HSCT) patients or \bigcirc Following needle stick injury

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:
Influenza vaccine Inj 60 mcg in 0.5 ml syringe (quadrivale	nt vaccine)
INITIATION – People over 65 Prerequisites (tick box where appropriate) O The patient is 65 years of age or over	
INITIATION – cardiovascular disease Prerequisites (tick boxes where appropriate)	
O Ischaemic heart disease	
or O Congestive heart failure	
O Rheumatic heart disease	
O Congenital heart disease	
or O Cerebro-vascular disease	
Note: hypertension and/or dyslipidaemia without evidence of end-organ dise	ease is excluded from funding.

INITIATION – chronic respiratory disease

or

Prerequisites (tick boxes where appropriate)

O Asthma, if on a regular preventative therapy

O Other chronic respiratory disease with impaired lung function

Note: asthma not requiring regular preventative therapy is excluded from funding.

Form	RS2013
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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:		

Influenza vaccine Inj 60 mcg in 0.5 ml syringe (quadrivalent vaccine) - continued

	С	Diabetes
	or C	Chronic renal disease
	or C	Any cancer, excluding basal and squamous skin cancers if not invasive
	or C	Autoimmune disease
	or C	Immune suppression or immune deficiency
	or C	
	or C	Transplant recipient
	or C	Neuromuscular and CNS diseases/ disorders
	or C	Haemoglobinopathies
	or C	Is a child on long term aspirin
	or C	Has a cochlear implant
	or C	Errors of metabolism at risk of major metabolic decompensation
	or C	Pre and post splenectomy
	or C	Down syndrome
	or C	ls pregnant
	or C	Is a child 4 years of age or under (inclusive) who has been hospitalised for respiratory illness or has a history of significant respiratory illness
or C		ients in a long-stay inpatient mental health care unit or who are compulsorily detained long-term in a forensic unit within a Public spital
ΓΙΟΝ	– Serio	ous mental health conditions or addiction

~	\bigcirc	Schizophrenia
or	Ο	Major depressive disorder
or	Ο	Bipolar disorder
or	Ο	Schizoaffective disorder
or	0	Person is currently accessing secondary or tertiary mental health and addiction services

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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:
Measles, mumps and rubella vaccine	
INITIATION – first dose prior to 12 months Re-assessment required after 3 doses Prerequisites (tick boxes where appropriate) O For primary vaccination in children or O or For revaccination following immunosuppression or O or For any individual susceptible to measles, mumps or rubella	
INITIATION – first dose after 12 months Re-assessment required after 2 doses Prerequisites (tick boxes where appropriate) O For primary vaccination in children or O or For revaccination following immunosuppression or O or For any individual susceptible to measles, mumps or rubella	

Note: Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes.

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:
Poliomyelitis vaccine	
INITIATION Re-assessment required after 3 doses Prerequisites (tick boxes where appropriate) O For partially vaccinated or previously unvaccinated individuals or O For revaccination following immunosuppression	3

Note: Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes.

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.

Name:		
		Name:
Vard:		NHI:
Varicella va	ccine [Chickenpox vaccine]	
Re-assessmer	primary vaccinations nt required after 1 dose (tick boxes where appropriate)	
or O	Any infant born on or after 1 April 2016 For previously unvaccinated children turning 11 years of (chickenpox)	d on or after 1 July 2017, who have not previously had a varicella infection
Re-assessmer	other conditions nt required after 2 doses (tick boxes where appropriate)	
	for non-immune patients: O With chronic liver disease who may in future be ca	ndidates for transplantation

greater than 28 days

I confirm that the above details are correct:

Signed: Date:

and

and

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	PATIENT:		
Name:	Name:		
Ward:	NHI:		

Human papillomavirus (6, 11, 16, 18, 31, 33, 45, 52 and 58) vaccine [HPV]

INITIATION – Children aged 14 years and under Re-assessment required after 2 doses Prerequisites (tick box where appropriate)	
O Children aged 14 years and under	

or	O Up to 3 doses for people aged 15 to 26 years inclusive O People aged 9 to 26 years inclusive and O Up to 3 doses for confirmed HIV infection or O Up to 3 doses people with a transplant (including stem cell) or O Up to 4 doses for Post chemotherapy	
	DN – Recurrent Respiratory Papillomatosis sites (tick boxes where appropriate) O Maximum of two doses for children aged 14 years and under	

	\sim					
(\cup	Maximum of three doses	for people	e aged 15	years and o	over

 ${
m O}~$ The person has recurrent respiratory papillomatosis

m O The person has not previously had an HPV vaccine

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.

PRES	CRIBER	PATIENT:
Name	:	Name:
Ward:		NHI:
Rota	virus oral vaccine	
Re-as	ATION ssessment required after 2 doses	
Prere	equisites (tick boxes where appropriate)	
	O First dose to be administered in infants aged under 14 weeks of and	of age
	O No vaccination being administered to children aged 24 weeks	or over

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.

PRES	CRI	BER		PATIENT:
Name	:			Name:
Ward:				NHI:
Varic	ella	a zos	ster vaccine [shingles vaccine]	
			beople aged 18 years and over (Shingrix) t required after 2 doses	
			(tick boxes where appropriate)	
		0	Pre- and post-haematopoietic stem cell transplant or cellular th	lerapy
	or	Ο	Pre- or post-solid organ transplant	
	or	Ο	Haematological malignancies	
	or	0	People living with poorly controlled HIV infection	
	or	Ο	Planned or receiving disease modifying anti-rheumatic drugs (DMARDs – targeted synthetic, biologic, or conventional synthetic) for
	or		polymyalgia rheumatica, systemic lupus erythematosus or rhei	umatoid arthritis
	or	\bigcirc	End stage kidney disease (CKD 4 or 5);	
		Ο	Primary immunodeficiency	

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:

COVID-19 vaccine

	initial dose (tick boxes where appropriate)
	One dose for previously unvaccinated people aged 12-15 years old
or O	Up to three doses for immunocompromised people aged 12-15 years old
or O	Up to two doses for previously unvaccinated people 16-29 years old
or or	Up to four doses for people aged 16-29 at high risk of severe illness
Ö	One dose for previously unvaccinated people aged 30 and older

INITIATION – additional dose

Prerequisites (tick box where appropriate)

O One additional dose every 6 months for people aged 30 years and over, additional dose is given at least 6 months after last dose

CONTINUATION – additional dose

Prerequisites (tick box where appropriate)

O One additional dose every 6 months for people aged 30 years and over, additional dose is given at least 6 months after last dose

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	PATIENT:
Name:	Name:
Ward:	NHI:

COVID-19 vaccine

		initial dose (tick boxes where appropriate)
1101		
	O	One dose for previously unvaccinated people aged 12-15 years old
	or O	Up to three doses for immunocompromised people aged 12-15 years old
	or O	Up to two doses for previously unvaccinated people 16-29 years old
	or O	Up to four doses for people aged 16-29 at high risk of severe illness
	or O	One dose for previously unvaccinated people aged 30 and older

INITIATION – additional dose

Prerequisites (tick box where appropriate)

O One additional dose every 6 months for people aged 30 years and over, additional dose is given at least 6 months after last dose

CONTINUATION – additional dose

Prerequisites (tick box where appropriate)

O One additional dose every 6 months for people aged 30 years and over, additional dose is given at least 6 months after last dose

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.

PRES	SCR	BER		PATIENT:
Name	e:			Name:
Ward:	:			NHI:
cov	ID-	19 va	accine	
			nitial dose (tick boxes where appropriate)	
		0	One dose for previously unvaccinated children aged 5-11 year	s old
	or	Ο	Up to three doses for immunocompromised children aged 5-11	years old

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:
COVID-19 vaccine	
INITIATION – initial dose	

Prerequisites (tick box where appropriate)

m O Up to three doses for previously unvaccinated children aged 6 months – 4 years at high risk of severe illness

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RS1169	Dexamphetamine sulphate	255
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RS1173	Naltrexone hydrochloride	257
RS1175	Sodium hyaluronate	.36
RS1176	Alpha tocopheryl acetate	.41
	Multivitamins – Powder Bivalirudin	
	Danaparoid	
RS1183	Defibrotide	.64
RS1184	Fondaparinux sodium	.65
RS1188	Filgrastim	.72
	Thalidomide	
	Pazopanib	
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	Bacillus calmette-guerin (BCG)	
RS1212	Carbohydrate and fat supplement4	150
RS1214	Standard Feeds4	170
RS1215	Diabetic Products	152
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	Adenosine - Inj 3 mg per ml, 10 ml vial	
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RS1302	Oxandroline - Tab 2.5 mg1	17
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	Fosfomycin	
	Amphotericin B - Inj 50 mg vial1 High Calorie Products	
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	Pyridoxal-5-phosphate	
	Aprotinin	
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	Risperidone	
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	Diphtheria, tetanus, pertussis and polio vaccine	
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	Preoperative carbohydrate feed 0.5 kcal/ml4	
	Rifaximin	
RS1417	Ferric carboxymaltose	.34
	Midodrine	
	Tobramycin Solution for inhalation 60 mg per ml, 5 ml1	
	Rivastigmine	
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RS1469 Protein	
RS1470 Fat-modified feed	
RS1473 Paediatric Products	
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influenzae type B vaccine	
RS1487 Measles, mumps and rubella vaccine	
RS1498 Multivitamin and mineral supplement	
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RS1588 Hepatitis B recombinant vaccine	
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RS1592 Eloncoxid	
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Alprostadil (RS1992)		Denosumab (RS1665)	
Aluminium chloride (RS1500)	51	Dexamethasone (RS1606)	439
Ambrisentan (RS1981)	92	Dexamphetamine sulphate (RS1169)	25!
Amikacin (RS1041)		Dexrazoxane (RS1695)	
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Aminolevulinic acid hydrochloride (RS1565)		Diazoxide (RS1028)	
Amphotericin B - Inj (liposomal) 50 mg vial (RS1071)		Diphtheria, tetanus and pertussis vaccine (RS1790)	
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Aripiprazole (RS2017)	245	Dornase alfa (RS1787)	42
Artemether with lumefantrine (RS1090)		Durvalumab (RS1926)	
Artesunate (RS1091)		Edrophonium chloride (RS1015)	
Atezolizumab (RS1986)		Eftrenonacog alfa (RS1684)	221 F(
Atovaquone with proguanil hydrochloride (RS1092)		Elemental and Semi-Elemental Products (RS1216)	
Azacitidine (RS1904)		Elexacaftor with tezacaftor, ivacaftor and ivacaftor (RS1950)	
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		Eltrombopag (RS1648)	
Aztreonam, Chloramphenicol (RS1277)		Emicizumab (RS1998)	
Bacillus calmette-guerin (BCG) (RS1206)		Empagliflozin; Empagliflozin with metformin hydrochloride (RS1852) .	
Bacillus calmette-guerin vaccine (RS1233)		Emtricitabine with tenofovir disoproxil (RS1902)	
Baricitinib (RS1876)		Enteral liquid peptide formula (RS1775)	
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Bedaquiline (RS1977)		Epoetin alfa (RS1660)	
Bee venom (RS1117)		Epoetin beta (RS1661)	
Bendamustine hydrochloride (RS1917)		Epoprostenol (RS1984)	
Benralizumab (RS1920)		Eptacog alfa (RS1704)	
Betaine (RS1794)	17	Eptifibatide (RS1759)	6
Betamethasone valerate with clioquinol (RS1125)	107	Erlotinib (RS1885)	
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Biotin (RS1330)	20	Etanercept (RS1879)	300
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COVID-19 vaccine (RS2030)		Ferric carboxymaltose (RS1417)	
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Cabergoline (RS1855)			
Calcium carbonate (RS1698)		Flucytosine (RS1279)	
Capsaicin (RS1309)		Fluticasone furoate with umeclidinium and vilanterol (RS2028)	
Capsaicin (RS1145)		Fondaparinux sodium (RS1184)	
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Carbohydrate and fat supplement (RS1212)	450	Fulvestrant (RS1732)	
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Cefepime (RS1049)	141	Gefitinib (RS1887)	
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	Povidone-iodine - Vaginal tab 200 mg (RS1354) 4 Preoperative carbohydrate feed 0.5 kcal/ml (RS1415) 4 Preterm formula (RS1224) 4 Primaquine phosphate (RS1097) 1 Propylthiouracil (RS1276) 1 Protease Inhibitors (RS1900) 2 Protein (RS1469) 4 Protoinamide (RS1084) 1 Pyrazinamide (RS1085) 1 Pyridoxal-5-phosphate (RS1331) 1 Pyrimethamine (RS1098) 1 Quinine dihydrochloride (RS1099) 1 Raloxifene (RS1666) 2 Ranibizumab (RS1703) 3 Rasburicase (RS1016) 2 Remdesivir (RS1912) 2 Ribociclib (RS2035) 2 Ribotavin (RS1833) 1 Rifabutin (RS1086) 1 Rifappicin (RS1087) 1 Rifappicin (RS1086) 1 Rifappicin (RS1146) 2 Remdesivir (RS1954) 2 Rifold (RS1785) 3 Rifuximab (RS1785) 3 Rifuginam (RS1954) 2	44 659 929 01 49 87 21 49 95 30 1.25 33 80 18 30 13 52 49 35
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Selenium (RS1929)		Ticarcillin with clavulanic acid (RS1054)	147
Siltuximab (RS1525)		Tigecycline (RS1059)	
Sirolimus (RS1991)		Tixagevimab with cilgavimab (RS1911)	380
Sodium chloride – Ínj (RS1297)		Tobramcyin (RS1475)	
Sodium hyaluronate (RS1175)		Tobramycin (RS1044)	
Sodium phenylbutyrate (RS1797)		Tobramycin Solution for inhalation 60 mg per ml, 5 ml (RS1435)	
Sodium stibogluconate (RS1100)		Tocilizumab (RS2025)	
Somatropin (RS1826)		Tolvaptan (RS1930)	
Spiramycin (RS1101)		Trastuzumab (Herzuma) (RS2005)	
Standard Feeds (RS1214)		Trastuzumab emtansine (RS1908)	
Stiripentol (RS1989)		Trientine (RS2026)	
Strand Transfer Inhibitors (RS1901)		Upadacitinib (RS1861)	
Streptomycin sulphate (RS1043)		Ursodeoxycholic acid (RS1824)	
Sucrose (RS1763)		Ustekinumab (RS1942)	
Sugammadex (RS1370)		Valganciclovir (RS1799)	207
Sulphadiazine (RS1067)		Vancomycin (RS1069)	
Sunitinib (RS1886)		Varenicline (RS1702)	
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Tacrolimus Ointment (RS1859)		Varicella zoster vaccine [shingles vaccine] (RS2039)	
Taliglucerase alfa (RS1897)		Vedolizumab (RS1943)	
Tamsulosin (RS1132)		Venetoclax (RS1713)	
Taurine (RS1834)		Vigabatrin (RS1865)	
Teicoplanin (RS1068)		Voriconazole (RS1075)	
Temozolomide (RS1994)		Yellow jacket wasp venom (RS1119)	
Terbutaline (RS1130)		Zanamivir - Powder for inhalation 5 mg (RS1369)	
Teriparatide (RS1143)		bosentan (RS1982)	
Thalidomide (RS1192)		sildenafil (Vedafil) (RS1983)	
Ticagrelor (RS1774)	68	sodium picosulfate (RS1843)	
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