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

PRESCRIBER		PATIENT:		
Name:		Name:		
Ward:		NHI:		
Siltuxima	ab			
Prerequis	sment required after 6 months  sites (tick boxes where appropriate)  Prescribed by, or recommended by a haematologist or rheumatologist the Health NZ Hospital.  Patient has severe HHV-8 negative idiopathic multicentric Cas  Treatment with an adequate trial of corticosteroids has proven	ineffective		
	JATION sment required after 12 months sites (tick box where appropriate)			
and t	Prescribed by, or recommended by a haematologist or rheumatologist the Health NZ Hospital.  The treatment remains appropriate and the patient has sustained im	st, or in accordance with a protocol or guideline that has been endorsed by		

I confirm that the above details are correct:

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