Form RS1660
January 2025

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: ....

Epoetin alfa

INITIATION – chronic renal failure
Prerequisites (tick boxes where appropriate)

- ○ Patient in chronic renal failure
- **and** ○ Haemoglobin is less than or equal to 100g/L
- **and**
  - ○ Patient does not have diabetes mellitus
  - **and** ○ Glomerular filtration rate is less than or equal to 30ml/min
  - **or**
  - ○ Patient has diabetes mellitus
  - **and** ○ Glomerular filtration rate is less than or equal to 45ml/min
  - **or**
  - ○ Patient is on haemodialysis or peritoneal dialysis

INITIATION – myelodysplasia*
Re-assessment required after 2 months
Prerequisites (tick boxes where appropriate)

- ○ Patient has a confirmed diagnosis of myelodysplasia (MDS)
- **and** ○ Has had symptomatic anaemia with haemoglobin < 100g/L and is red cell transfusion-dependent
- **and** ○ Patient has very low, low or intermediate risk MDS based on the WHO classification-based prognostic scoring system for myelodysplastic syndrome (WPSS)
- **and** ○ Other causes of anaemia such as B12 and folate deficiency have been excluded
- **and** ○ Patient has a serum epoetin level of < 500 IU/L
- **and** ○ 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)

- ○ The patient's transfusion requirement continues to be reduced with epoetin treatment
- **and** ○ Transformation to acute myeloid leukaemia has not occurred
- **and** ○ The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week

I confirm that the above details are correct:

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

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

Name: ....

Ward: ....

PATIENT:

Name: ....

NHI: ....

Epoetin alfa *- continued*

INITIATION – all other indications

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.

and

❍ For use in patients where blood transfusion is not a viable treatment alternative

Note: Indications marked with * are unapproved indications

HOSPITAL

I confirm that the above details are correct:

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