

Use this checklist to determine if a patient meets the restrictions for funding 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:

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)

Ocular neovascularisation

or

Exudative ocular angiopathy

I confirm that the above details are correct:

Signed: Date: