HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 1

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

PRESCRIBER			PATIENT:			
Name:			Name:			
Ward:			NHI:			
Fulve	estrant					
Re-a		t required after 6 months (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 Newspital.					
	and O and O	Patient has oestrogen-receptor positive locally advanced or metastatic breast cancer Patient has disease progression following prior treatment with an aromatase inhibitor or tamoxifen for their locally advanced or metastatic disease Treatment to be given at a dose of 500 mg monthly following loading doses Treatment to be discontinued at disease progression				
CONTINUATION Re-assessment required after 6 months Prerequisites (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.						
and	and O and O	Treatment remains appropriate and patient is benefitting from Treatment to be given at a dose of 500 mg monthly No evidence of disease progression	treatment			
<u> </u>						

I confirm that the above details are correct:

Cianad.	Data.	
Signeg	 Date	