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

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Ticagrelor

INITIATION

Prerequisites (tick box where appropriate)

- ○ Restricted to treatment of acute coronary syndromes specifically for patients who have recently (within the last 60 days) been diagnosed with an ST-elevation or a non-ST-elevation acute coronary syndrome, and in whom fibrinolytic therapy has not been given in the last 24 hours and is not planned

INITIATION – thrombosis prevention neurological stenting

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

- ○ Patient has had a neurological stenting procedure* in the last 60 days

or

- ○ Patient is about to have a neurological stenting procedure performed*

and

- ○ Patient has demonstrated clopidogrel resistance using the P2Y12 (VerifyNow) assay or another appropriate platelet function assay and requires antiplatelet treatment with ticagrelor

or

- ○ Clopidogrel resistance has been demonstrated by the occurrence of a new cerebral ischemic event

or

- ○ Clopidogrel resistance has been demonstrated by the occurrence of transient ischemic attack symptoms referable to the stent.

CONTINUATION – thrombosis prevention neurological stenting

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

- ○ Patient is continuing to benefit from treatment

and

- ○ Treatment continues to be clinically appropriate

INITIATION – Percutaneous coronary intervention with stent deployment

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

- ○ Patient has undergone percutaneous coronary intervention

and

- ○ Patient has had a stent deployed in the previous 4 weeks

and

- ○ Patient is clopidogrel-allergic**

INITIATION – Stent thrombosis

Prerequisites (tick box where appropriate)

- ○ Patient has experienced cardiac stent thrombosis whilst on clopidogrel

INITIATION – Myocardial infarction

Re-assessment required after 1 week

Prerequisites (tick box where appropriate)

- ○ For short term use while in hospital following ST-elevated myocardial infarction

I confirm that the above details are correct:

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

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PRESCRIBER

Name: .....

Ward: .....

PATIENT:

Name: .....

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

I confirm that the above details are correct:

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