RS1827 - Pegylated interferon alfa-2a

Chronic Hepatitis C - genotype 1 infection treatment more than 4 years prior - INITIATION	
Chronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV or genotype 2 or 3 post liver transplar - INITIATION	
Chronic hepatitis C - genotype 2 or 3 infection without co-infection with HIV - INITIATIONHepatitis B - INITIATION	
Myeloproliferative disorder or cutaneous T cell lymphoma - INITIATION	.3
Ocular surface squamous neoplasia - INITIATIÓN Ocular surface squamous neoplasia - CONTINUATION	. 4
Post-allogenic bone marrow transplant - INITIATION Post-allogenic bone marrow transplant - CONTINUATION	. 4

I confirm that the above details are correct:

Signed: Date:

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	R PATIENT:	
Name:		
Ward:	NHI:	
Pegylated in	interferon alfa-2a	
	- Chronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV or genotype 2 or 3 post liver transplant nent required after 48 weeks	
Prerequisites	es (tick boxes where appropriate)	
or O	Patient has chronic hepatitis C, genotype 1, 4, 5 or 6 infection	
or	Patient has chronic hepatitis C and is co-infected with HIV	
	Patient has chronic hepatitis C genotype 2 or 3 and has received a liver transplant	
treatment since	der stopping treatment if there is absence of a virological response (defined as at least a 2-log reduction in viral load) following 12 week note this is predictive of treatment failure.	
	ducing treatment to 24 weeks if serum HCV RNA level at Week 4 is undetectable by sensitive PCR assay (less than 50IU/ml) AND Base RNA is less than 400,000IU/ml.	iline
CONTINUATIO	TION – Chronic hepatitis C - genotype 1 infection	
Re-assessmer	nent required after 48 weeks es (tick boxes where appropriate)	
	escribed by, or recommended by a gastroenterologist, infectious disease specialist or general physician, or in accordance with a protocc ideline that has been endorsed by the Health NZ Hospital.	l or
and	Patient has chronic hepatitis C, genotype 1	
and	Patient has had previous treatment with pegylated interferon and ribavirin	
or	O Patient has responder relapsed	
	O Patient was a partial responder	
and	Patient is to be treated in combination with boceprevir	
INITIATION —	– Chronic Hepatitis C - genotype 1 infection treatment more than 4 years prior	
Re-assessmer	es (tick boxes where appropriate)	
	escribed by, or recommended by a gastroenterologist, infectious disease specialist or general physician, or in accordance with a protoccideline that has been endorsed by the Health NZ Hospital.	ol or
O	Patient has chronic hepatitis C, genotype 1	
and	Patient has had previous treatment with pegylated interferon and ribavirin	
and	O Patient has responder relapsed	
or	O Patient was a partial responder	
or	O Patient received interferon treatment prior to 2004	
and	Patient is to be treated in combination with boceprevir	

I confirm that the above details are correct:

Signed: Date:

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:					
Pegylated interferon alfa-2a - continued						
INITIATION – Chronic hepatitis C - genotype 2 or 3 infection without c Re-assessment required after 6 months	o-infection with HIV					
Prerequisites (tick box where appropriate)						
O Patient has chronic hepatitis C, genotype 2 or 3 infection						
INITIATION – Hepatitis B Re-assessment required after 48 weeks						
Prerequisites (tick boxes where appropriate)						
Prescribed by, or recommended by a gastroenterologist, infectious guideline that has been endorsed by the Health NZ Hospital.	s disease specialist or general physician, or in accordance with a protocol or					
Patient has confirmed Hepatitis B infection (HBsAg positive	for more than 6 months)					
Patient is Hepatitis B treatment-naive						
ALT > 2 times Upper Limit of Normal						
and HBV DNA < 10 log10 IU/ml and						
O HBeAg positive						
Serum HBV DNA greater than or equal to 2,000 units moderate fibrosis)	s/ml and significant fibrosis (greater than or equal to Metavir Stage F2 or					
and Compensated liver disease	Compensated liver disease and No continuing alcohol abuse or intravenous drug use					
O No continuing alcohol abuse or intravenous drug use						
Not co-infected with HCV, HIV or HDV						
O Neither ALT nor AST > 10 times upper limit of normal and						
O No history of hypersensitivity or contraindications to pegyla	ted interferon					
INITIATION – myeloproliferative disorder or cutaneous T cell lymphon Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	na					
O Patient has a cutaneous T cell lymphoma*						
Patient has a myeloproliferative disorder*						
Patient is intolerant of hydroxyurea						
Treatment with anagrelide and busulfan is not clinical	ly appropriate					
O Patient has a myeloproliferative disorder						
O Patient is pregnant, planning pregnancy or lactating						

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:				
Pegylated interferon alfa-2a - continued				
CONTINUATION – myeloproliferative disorder or cutaneous T cell lymphoma Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) One evidence of disease progression and One the treatment remains appropriate and patient is benefitting from treatment and One Patient has a cutaneous T cell lymphoma* One Patient has a myeloproliferative disorder* and One Remains intolerant of hydroxyurea and treatment with anagrelide and busulfan remains clinically inappropriate One Patient is pregnant, planning pregnancy or lactating				
Note: Indications marked with * are unapproved indications				
INITIATION – ocular surface squamous neoplasia Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Patient has ocular surface squamous neoplasia*				
CONTINUATION – ocular surface squamous neoplasia Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O The treatment remains appropriate and patient is benefitting from treatment Note: Indications marked with * are unapproved indications				
INITIATION – post-allogenic bone marrow transplant Re-assessment required after 3 months Prerequisites (tick box where appropriate) O Patient has received an allogeneic bone marrow transplant* and has evidence of disease relapse				
CONTINUATION – post-allogenic bone marrow transplant Re-assessment required after 3 months Prerequisites (tick box where appropriate) O Patient is responding and ongoing treatment remains appropriate Note: Indications marked with * are unapproved indications				

I confirm that the above details are correct:

Signed: Date: