# 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: .....

## Olaparib

**INITIATION – Ovarian cancer**
Re-assessment required after 12 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**

- ○ Patient has a high-grade serous* epithelial ovarian, fallopian tube, or primary peritoneal cancer

**and**

- ○ There is documentation confirming pathogenic germline BRCA1 or BRCA2 gene mutation

**and**

- ○ Patient has newly diagnosed, advanced disease

  **and**

  ○ Patient has received one line** of previous treatment with platinum-based chemotherapy

  **and**

  ○ Patient's disease must have experienced a partial or complete response to the first-line platinum-based regimen

**or**

- ○ Patient has received at least two lines** of previous treatment with platinum-based chemotherapy

  **and**

  ○ Patient has platinum sensitive disease defined as disease progression occurring at least 6 months after the last dose of the penultimate line** of platinum-based chemotherapy

  **and**

  ○ Patient's disease must have experienced a partial or complete response to treatment with the immediately preceding platinum-based regimen

  **and**

  ○ Patient has not previously received funded olaparib treatment

**and**

- ○ Treatment will be commenced within 12 weeks of the patient's last dose of the immediately preceding platinum-based regimen

**and**

- ○ Treatment to be administered as maintenance treatment

**and**

- ○ Treatment not to be administered in combination with other chemotherapy



I confirm that the above details are correct:

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

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**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

## Olaparib *- continued*

**CONTINUATION – Ovarian cancer**
Re-assessment required after 12 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**

- ○ Treatment remains clinically appropriate and patient is benefitting from treatment

**and**

- ○ No evidence of progressive disease

**or**

- ○ Evidence of residual (not progressive) disease and the patient would continue to benefit from treatment in the clinician's opinion

**and**

- ○ Treatment to be administered as maintenance treatment

**and**

- ○ Treatment not to be administered in combination with other chemotherapy

**and**

- ○ Patient has received one line** of previous treatment with platinum-based chemotherapy

**and**

- ○ Documentation confirming that the patient has been informed and acknowledges that the funded treatment period of olaparib will not be continued beyond 2 years if the patient experiences a complete response to treatment and there is no radiological evidence of disease at 2 years

**or**

- ○ Patient has received at least two lines** of previous treatment with platinum-based chemotherapy

Note: *Note "high-grade serous" includes tumours with high-grade serous features or a high-grade serous component.
**A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments.



I confirm that the above details are correct:

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