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: .....

Mepolizumab

INITIATION – Severe eosinophilic asthma
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a respiratory physician or clinical immunologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ○ Patient must be aged 12 years or older

and

- ○ Patient must have a diagnosis of severe eosinophilic asthma documented by a respiratory physician or clinical immunologist

and

- ○ Conditions that mimic asthma eg. vocal cord dysfunction, central airway obstruction, bronchiolitis etc. have been excluded

and

- ○ Patient has a blood eosinophil count of greater than 0.5 × 10^9 cells/L in the last 12 months

and

- ○ Patient must be adherent to optimised asthma therapy including inhaled corticosteroids (equivalent to at least 1000 mcg per day of fluticasone propionate) plus long acting beta-2 agonist, or budesonide/formoterol as part of the single maintenance and reliever therapy regimen, unless contraindicated or not tolerated

and

- ○ Patient has had at least 4 exacerbations needing systemic corticosteroids in the previous 12 months, where an exacerbation is defined as either documented use of oral corticosteroids for at least 3 days or parenteral corticosteroids

or

- ○ Patient has received continuous oral corticosteroids of at least the equivalent of 10 mg per day over the previous 3 months

and

- ○ Treatment is not to be used in combination with subsidised benralizumab

and

- ○ Patient has an Asthma Control Test (ACT) score of 10 or less. Baseline measurements of the patient's asthma control using the ACT and oral corticosteroid dose must be made at the time of application, and again at around 52 weeks after the first dose to assess response to treatment

and

- ○ Patient has not previously received an anti-IL5 biological therapy for their severe eosinophilic asthma

or

- ○ Patient was refractory or intolerant to previous anti-IL5 biological therapy

and

- ○ Patient was not eligible to continue treatment with previous anti-IL5 biological therapy and discontinued within 12 months of commencing treatment

CONTINUATION – Severe eosinophilic asthma
Re-assessment required after 2 years
Prerequisites (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a respiratory physician or clinical immunologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ○ An increase in the Asthma Control Test (ACT) score of at least 5 from baseline

and

- ○ Exacerbations have been reduced from baseline by 50% as a result of treatment with mepolizumab

or

- ○ Reduction in continuous oral corticosteroid use by 50% or by 10 mg/day while maintaining or improving asthma control

I confirm that the above details are correct:

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

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PRESCRIBER

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Mepolizumab *- continued*

INITIATION – eosinophilic granulomatosis with polyangiitis
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

- ❍ The patient has eosinophilic granulomatosis with polyangiitis

and

- ❍ The patient has trialled and not received adequate benefit from at least one of the following for at least three months (unless contraindicated to all): azathioprine, cyclophosphamide, leflunomide, methotrexate, mycophenolate, or rituximab

and

- ❍ The patient has trialled prednisone for a minimum of three months and is unable to maintain disease control at doses below 7.5 mg per day

or

- ❍ Corticosteroids are contraindicated

CONTINUATION – eosinophilic granulomatosis with polyangiitis
Re-assessment required after 12 months
Prerequisites (tick box where appropriate)

- ❍ Patient has no evidence of clinical disease progression

I confirm that the above details are correct:

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