

#### Therapeutic Groups

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#### **Alimentary Tract and Metabolism**



PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Calcium carbonate	
INITIATION Prerequisites (tick box where appropriate)	
Only when prescribed for patients unable to swallow calcium carbor	nate tablets or where calcium carbonate tablets are inappropriate.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Budesonide	
INITIATION – Crohn's disease Prerequisites (tick boxes where appropriate)	
Mild to moderate ileal, ileocaecal or proximal Crohn's disease	
O Diabetes  or O Cushingoid habitus  or O Steoporosis where there is significant risk of fracture  or O Severe acne following treatment with conventional cortic  or O History of severe psychiatric problems associated with cort  or O History of major mental illness (such as bipolar affective causing relapse is considered to be high  O Relapse during pregnancy (where conventional corticosis	orticosteroid treatment disorder) where the risk of conventional corticosteroid treatment
INITIATION – Collagenous and lymphocytic colitis (microscopic colitis)  Prerequisites (tick box where appropriate)  O Patient has a diagnosis of microscopic colitis (collagenous or lympho	ocytic colitis) by colonoscopy with biopsies
INITIATION – Gut Graft versus Host disease Prerequisites (tick box where appropriate)  O Patient has gut Graft versus Host disease following allogenic bone n	narrow transplantation

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PRESCRIBE	ΕR			PATIENT:
Name:				Name:
Ward:				NHI:
Budesoni	de	- cor	ntinued	
Re-assessn	nen	t requ	irrhotic autoimmune hepatitis ired after 6 months ooxes where appropriate)	
	)	Patie	nt has autoimmune hepatitis*	
and and	)	Patie	nt does not have cirrhosis	
		O	Diabetes	
	or	0	Cushingoid habitus	
	or or	0	Osteoporosis where there is significant risk of fracture	
		0	Severe acne following treatment with conventional cortic	costeroid therapy
	or	0	History of severe psychiatric problems associated with o	orticosteroid treatment
	or	0	History of major mental illness (such as bipolar affective causing relapse is considered to be high	disorder) where the risk of conventional corticosteroid treatment
	or	0	Relapse during pregnancy (where conventional corticos	teroids are considered to be contraindicated)
	or	0	Adolescents with poor linear growth (where conventional	I corticosteroid use may limit further growth)
Note: Indica	atio	ns ma	arked with * are unapproved indications.	
Re-assessn	nen	t requ	non-cirrhotic autoimmune hepatitis ired after 6 months nox where appropriate)	
Отг	eatr	ment	remains appropriate and the patient is benefitting from the	e treatment

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Signed.	Date:	
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#### Form RS1703 January 2025

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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.

PRES	SCRI	BER	PATIENT:
Name	e:		Name:
Ward	:		NHI:
Rani	itidi	ne	
INITI Prer		Sites (tick boxes where appropriate)	
		O For continuation use	
	or	O Routine prevention of allergic reactions.	

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PATIENT:
Name:
NHI:

#### Form RS1261 January 2025

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 9

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:
L-ornithine L-aspartate	
INITIATION	
Prerequisites (tick box where appropriate)	
O For patients with chronic hepatic encephalopathy who have not resp is contraindicated	onded to treatment with, or are intolerant to lactulose, or where lactulose

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Rifaximin	
INITIATION Prerequisites (tick box where appropriate)	
O For patients with hepatic encephalopathy despite an adequate trial of	of maximum tolerated doses of lactulose

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#### Form RS1028 January 2025

#### HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Diazoxide	
INITIATION Prerequisites (tick box where appropriate)	
O For patients with confirmed hypoglycaemia caused by hyperinsulinis	m



I confirm that the above details are correct:

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

PATIENT:
Name:
NHI:
ide
action (LVEF) of less than or equal to 40% pinion of the treating practitioner the patient would benefit from treatment  thronic heart failure treatment  agonist  agonist  agonist  disease risk of 15% or greater according to a validated cardiovascular due to being diagnosed with type 2 diabetes during childhood or as a bb)*  achieved despite the regular use of at least one blood-glucose lowering east 3 months  or renal complications of diabetes.  acardiovascular disease event (i.e. angina, myocardial infarction, percutaneous emic attack, ischaemic stroke, peripheral vascular disease), congestive heart eatinine ratio greater than or equal to 3 mg/mmol, in at least two out of three  .73m2 in the presence of diabetes, without alternative cause.
atment is not to be given in combination with a funded GLP-1 unless receiving trailing the straightful trailing.

PRESCRIBER	PATIENT:
me: Name:	
Ward:	NHI:
Ursodeoxycholic acid	
INITIATION – Alagille syndrome or progressive familial intrahepatic chole Prerequisites (tick boxes where appropriate)	estasis
O Patient has been diagnosed with Alagille syndrome O Patient has progressive familial intrahepatic cholestasis	
INITIATION – Chronic severe drug induced cholestatic liver injury Prerequisites (tick boxes where appropriate)	
Patient has chronic severe drug induced cholestatic liver injury and Cholestatic liver injury not due to Total Parenteral Nutrition (TF	
O Treatment with ursodeoxycholic acid may prevent hospital adn	nission or reduce duration of stay
INITIATION – Primary biliary cholangitis Prerequisites (tick boxes where appropriate)	
Primary biliary cholangitis confirmed by antimitochondrial antibody titre (AMA) > 1:80, and raised cholestatic liver enzymes with or without raised serum IgM or, if AMA is negative by liver biopsy and	
O Patient not requiring a liver transplant (bilirubin > 100 umol/l; c	ecompensated cirrhosis
INITIATION – Pregnancy Prerequisites (tick box where appropriate)	
O Patient diagnosed with cholestasis of pregnancy	
INITIATION – Haematological transplant Prerequisites (tick boxes where appropriate)	
Patient at risk of veno-occlusive disease or has hepatic impair cell or bone marrow transplantation	ment and is undergoing conditioning treatment prior to allogenic stem
O Treatment for up to 13 weeks	
INITIATION – Total parenteral nutrition induced cholestasis Prerequisites (tick boxes where appropriate)	
Paediatric patient has developed abnormal liver function as inc	dicated on testing which is likely to be induced by TPN
O Liver function has not improved with modifying the TPN composition	osition

I confirm that the above details are correct:

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

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Ursodeoxycholic acid - continued	
INITIATION – prevention of sinusoidal obstruction syndrome Re-assessment required after 6 months	
Prerequisites (tick boxes where appropriate)	
O The patient is enrolled in the Children's Oncology Group AA	LL1732 trial
The patient has leukaemia/lymphoma and is receiving inotuz	zumab ozogamicin

PRES	CRIBE	R	PATIENT:
Name	:		Name:
Ward:			NHI:
Meth	ylnalt	rexone bromide	
		Opioid induced constipation     (tick boxes where appropriate)	
	and	The patient is receiving palliative care	
		Oral and rectal treatments for opioid induced constipation Oral and rectal treatments for opioid induced constipation	
Re-as	ssessm	Opioid induced constipation outside of palliative care ent required after 14 days es (tick boxes where appropriate)	
	and	Individual has opioid induced constipation	
	and	Oral and rectal treatments for opioid induced constipation, incl	uding bowel-cleansing preparations, are ineffective or inappropriate
		Mechanical bowel obstruction has been excluded	

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PRES	CRIBER		PATIENT:
Name	e:		Name:
Ward			NHI:
sodi	um pico	osulfate	
	ATION equisites	(tick boxes where appropriate)	
	The patient is a child with problematic constipation despite an adequate trial of other oral pharmacotherapies including macrogol where practicable and		
	O	The patient would otherwise require a high-volume bowel clea	nsing preparation

PRESCR	RIBER	PATIENT:
Name: .		Name:
Ward:		NHI:
Betaine	•	
	essment required after 12 months  ilsites (tick boxes where appropriate)	ordance with a protocol or guideline that has been endorsed by the Health
arid	O The patient has a confirmed diagnosis of homocystinuria	
ar	or O A cystathionine beta-synthase (CBS) deficiency O A 5,10-methylene-tetrahydrofolate reductase (MTHFR) or O A disorder of intracellular cobalamin metabolism	deficiency
	O An appropriate homocysteine level has not been achieved des	spite a sufficient trial of appropriate vitamin supplementation
Re-asse	IUATION sssment required after 12 months sisites (tick box where appropriate)	
and	Prescribed by, or recommended by a metabolic physician, or in account NZ Hospital.  The treatment remains appropriate and the patient is benefiting from	ordance with a protocol or guideline that has been endorsed by the Health

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Signed.	Date:	
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PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Levocarnitine		
INITIATION		
Prerequisites (tick box where appropriate)		
O Prescribed by, or recommended by a neurologist, metabolic physician or metabolic disorders dietitian, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		

PRESCRIE	BER	PATIENT:
Name:		Name:
Ward:		NHI:
Sodium	phenylbutyrate	
Prerequis	sment required after 12 months  sites (tick box where appropriate)  Prescribed by, or recommended by a metabolic physician, or in acconditional according to the second second second second second second second second sec	ordance with a protocol or guideline that has been endorsed by the Health iciency of carbamylphosphate synthetase, ornithine transcarbamylase or
CONTINUATION  Re-assessment required after 12 months  Prerequisites (tick box where appropriate)  O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  and  The treatment remains appropriate and the patient is benefiting from treatment		
	The treatment remains appropriate and the patient is benefiting from	ueament

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Biotin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a metabolic physician or metabolic been endorsed by the Health NZ Hospital.	olic disorders dietitian, or in accordance with a protocol or guideline that has

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pyridoxal-5-phosphate	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a neurologist, metabolic physicia guideline that has been endorsed by the Health NZ Hospital.	n or metabolic disorders dietitian, or in accordance with a protocol or

PRES	SCRIBER	PATIENT:
Name	e:	Name:
Ward:	·	NHI:
Gals	sulfase	
Re-a	IATION assessment required after 12 months requisites (tick boxes where appropriate)	
( and	Prescribed by, or recommended by a metabolic physician, or in a NZ Hospital.	accordance with a protocol or guideline that has been endorsed by the Health
	The patient has been diagnosed with mucopolysaccharide	osis VI
	enzyme activity assay in leukocytes or skin fibroblas	alactosamine-4-sulfatase (arylsulfatase B) deficiency confirmed by either sts ient has a sibling who is known to have mucopolysaccharidosis VI
Re-a		accordance with a protocol or guideline that has been endorsed by the Health
and	adjustment of infusion rates	patient is benefiting from treatment ons which were not preventable by appropriate pre-medication and/or re disease where the long term prognosis is unlikely to be influenced by
	and Patient has not developed another medical condition that it	might reasonably be expected to compromise a response to ERT

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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.

RESCRIBER	PATIENT:
ame:	Name:
ard:	NHI:
glucosida	use Alfa
rerequisites O Pres	nt required after 12 months (tick boxes where appropriate) cribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health Hospital.
	The patient is aged up to 24 months at the time of initial application and has been diagnosed with infantile Pompe disease
and or or and on an analysis o	<ul> <li>Diagnosis confirmed by documented deficiency of acid alpha-glucosidase by prenatal diagnosis using chorionic villus biopsies and/or cultured amniotic cells</li> <li>Documented deficiency of acid alpha-glucosidase, and urinary tetrasaccharide testing indicating a diagnostic elevation of glucose tetrasaccharides</li> <li>Documented deficiency of acid alpha-glucosidase, and documented molecular genetic testing indicating a disease-causing mutation in the acid alpha-glucosidase gene (GAA gene)</li> </ul>
erequisites O Pres	nt required after 12 months (tick boxes where appropriate) cribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health Hospital.
and on and	The treatment remains appropriate for the patient and the patient is benefiting from treatment  Alglucosidase alfa to be administered at doses no greater than 20 mg/kg every 2 weeks  Patient has not had severe infusion-related adverse reactions which were not preventable by appropriate pre-medication and/or
and O and O and	Patient has not developed another life threatening or severe disease where the long term prognosis is unlikely to be influenced by ERT  Patient has not developed another medical condition that might reasonably be expected to compromise a response to ERT  There is no evidence of life threatening progression of respiratory disease as evidenced by the needed for > 14 days of invasive
and	ventilation

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.

PRES	CRIB	BER		PATIENT:
Name:	:			Name:
Ward:				NHI:
ldurs	ulfa	se		
	ssess quis	ites Presc	t required after 24 weeks (tick boxes where appropriate) cribed by, or recommended by a metabolic physician, or in accoospital.	rdance with a protocol or guideline that has been endorsed by the Health
	and	0	The patient has been diagnosed with Hunter Syndrome (muco	polysacchardosis II)
		or	cultured skin fibroblasts	Ifatase deficiency in white blood cells by either enzyme assay in
	and (	<u></u> О	Patient is going to proceed with a haematopoietic stem cell tra would be bridging treatment to transplant	nsplant (HSCT) within the next 3 months and treatment with idursulfase
	and	0		ratory failure prior to starting Enzyme Replacement Therapy (ERT)
			Idursulfase to be administered for a total of 24 weeks (equivale 0.5 mg/kg every week	ent to 12 weeks pre- and 12 weeks post-HSCT) at doses no greater than

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PRESCRI	BER	PATIENT:
Name:		
Ward:		NHI:
Laronid	ase	
	sites Prese	nt required after 24 weeks (tick boxes where appropriate) cribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health dospital.
and	O	The patient has been diagnosed with Hurler Syndrome (mucopolysacchardosis I-H)
	or	O Diagnosis confirmed by demonstration of alpha-L-iduronidase deficiency in white blood cells by either enzyme assay in cultured skin fibroblasts O Detection of two disease causing mutations in the alpha-L-iduronidase gene and patient has a sibling who is known to have Hurler syndrome
and		Patient is going to proceed with a haematopoietic stem cell transplant (HSCT) within the next 3 months and treatment with laronidase would be bridging treatment to transplant  Patient has not required long-term invasive ventilation for respiratory failure prior to starting Enzyme Replacement Therapy (ERT)
	$\cup$	Laronidase to be administered for a total of 24 weeks (equivalent to 12 weeks pre- and 12 post-HSCT) at doses no greater than 100 units/kg every week

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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.

SCRII	BER	PATIENT:
e:		
		NHI:
luc	eras	e alfa
equi:	smen sites Presc	It required after 12 months (tick boxes where appropriate) cribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Healiospital.
and	O	The patient has a diagnosis of symptomatic type 1 or type 3* Gaucher disease confirmed by the demonstration of specific deficiency of glucocerebrosidase in leukocytes or cultured skin fibroblasts, and genotypic analysis  Patient does not have another life-threatening or severe disease where the prognosis is unlikely to be influenced by enzyme replacement therapy (ERT) or the disease might be reasonably expected to compromise a response to ERT  O Patient has haematological complications of Gaucher disease  Patient has skeletal complications of Gaucher disease  Patient has significant liver dysfunction or hepatomegaly attributable to Gaucher disease
and	or	Patient has reduced vital capacity from clinically significant or progressive pulmonary disease due to Gaucher disease  Patient is a child and has experienced growth failure with significant decrease in percentile linear growth over a 6-12 month period  Taliglucerase alfa is to be administered at a dose no greater than 30 unit/kg every other week rounded to the nearest whole vial (200 units)
Ind	licatio	n marked with * is an unapproved indication
sses equi:	Preso accor	It required after 3 years (tick boxes where appropriate) cribed by, or recommended by a metabolic physician or any relevant practitioner on the recommendation of a metabolic physician, or in redance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	$\cup$	Patient has demonstrated a symptomatic improvement and has maintained improvements in the main symptom or symptoms for which therapy was started
and		Patient has demonstrated a clinically objective improvement or no deterioration in haemoglobin levels, platelet counts and liver and spleen size  RRadiological (MRI) signs of bone activity performed at two years since initiation of treatment, and five yearly thereafter, demonstrate no deterioration shown by the MRI, compared with MRI taken immediately prior to commencement of therapy or adjusted dose

RESCRIBER		PAHEN	PATIENT:		
ame:			Name:		
rd:					
ropteri	in dih	nydrochloride			
	-	quired after 1 month boxes where appropriate)			
	escribed Z Hospit	ed by, or recommended by a metabolic physician, or in accordance wital.	th a protocol or guideline that has been endorsed by the Health		
and	) Patio	tient has phenylketonuria (PKU) and is pregnant or actively planning	o become pregnant		
and	) Trea	atment with sapropterin is required to support management of PKU of	uring pregnancy		
and	) Sap	propterin to be administered at doses no greater than a total daily do	e of 20 mg/kg		
and _	) Sap	propterin to be used alone or in combination with PKU dietary manage	ement		
		al treatment duration with sapropterin will not exceed 22 months for gnant) and treatment will be stopped after delivery	each pregnancy (includes time for planning and becoming		
requisite	FION nent reques (tick	quired after 12 months s boxes where appropriate) ed by, or recommended by a metabolic physician, or in accordance w	th a protocol or guideline that has been endorsed by the Health		
assessm requisite	FION nent reques (tick	quired after 12 months s boxes where appropriate) ed by, or recommended by a metabolic physician, or in accordance w	th a protocol or guideline that has been endorsed by the Health		
assessm requisite Pre NZ	FION nent reques (tick escribed Hospit	quired after 12 months s boxes where appropriate) ed by, or recommended by a metabolic physician, or in accordance w	ated an adequate response to a 2 to 4 week trial of		
assessm requisite Pre NZ	FION nent reques (tick	quired after 12 months s boxes where appropriate) ed by, or recommended by a metabolic physician, or in accordance wital.  Following the initial one-month approval, the patient has demonst	ated an adequate response to a 2 to 4 week trial of levels to support management of PKU during pregnancy emonstrated response to treatment with sapropterin and		
assessm requisite Pre NZ	FION nent reques (tick escribed Hospit	quired after 12 months a boxes where appropriate)  ad by, or recommended by a metabolic physician, or in accordance weital.  Following the initial one-month approval, the patient has demonst sapropterin with a clinically appropriate reduction in phenylalanine  On subsequent renewal applications, the patient has previously described by the patient of the proviously described by the patient of t	ated an adequate response to a 2 to 4 week trial of levels to support management of PKU during pregnancy emonstrated response to treatment with sapropterin and		
assessm requisite O Pre NZ	FION nent reques (tick esscribect Hospit  or	quired after 12 months a boxes where appropriate)  ad by, or recommended by a metabolic physician, or in accordance weital.  Following the initial one-month approval, the patient has demonst sapropterin with a clinically appropriate reduction in phenylalanine  On subsequent renewal applications, the patient has previously described by the patient of the proviously described by the patient of t	ated an adequate response to a 2 to 4 week trial of levels to support management of PKU during pregnancy emonstrated response to treatment with sapropterin and t of PKU during pregnancy		
assessm requisite O Pre NZ	FION nent reques (tick esscribect Hospit  or or	quired after 12 months a boxes where appropriate)  and by, or recommended by a metabolic physician, or in accordance weital.  Following the initial one-month approval, the patient has demonst sapropterin with a clinically appropriate reduction in phenylalanine  On subsequent renewal applications, the patient has previously demaintained adequate phenylalanine levels to support management	ated an adequate response to a 2 to 4 week trial of levels to support management of PKU during pregnancy emonstrated response to treatment with sapropterin and tof PKU during pregnancy		
assessm requisite O Pre NZ	FION nent reques (tick esscribect Hospit  or	quired after 12 months a boxes where appropriate)  and by, or recommended by a metabolic physician, or in accordance weital.  Following the initial one-month approval, the patient has demonst sapropterin with a clinically appropriate reduction in phenylalanine  On subsequent renewal applications, the patient has previously demaintained adequate phenylalanine levels to support management	ated an adequate response to a 2 to 4 week trial of levels to support management of PKU during pregnancy emonstrated response to treatment with sapropterin and to f PKU during pregnancy will not continue after delivery		
assessm requisite Pre NZ	FION nent reques (tick esscribect Hospit  or or or	quired after 12 months a boxes where appropriate)  and by, or recommended by a metabolic physician, or in accordance weital.  Following the initial one-month approval, the patient has demonst sapropterin with a clinically appropriate reduction in phenylalanine  On subsequent renewal applications, the patient has previously demaintained adequate phenylalanine levels to support management  Patient continues to be pregnant and treatment with sapropterin weighted planning a pregnancy and this is the first renewning the patient with sapropterin is required for a second or subsequents.	ated an adequate response to a 2 to 4 week trial of levels to support management of PKU during pregnancy emonstrated response to treatment with sapropterin and t of PKU during pregnancy  ill not continue after delivery al for treatment with sapropterin  pregnancy to support management of their PKU during		
assessm requisite Pre NZ	rion lent reques (tick escribect Hospit  or or or Sap	quired after 12 months a boxes where appropriate)  ed by, or recommended by a metabolic physician, or in accordance weital.  Following the initial one-month approval, the patient has demonst sapropterin with a clinically appropriate reduction in phenylalanine  On subsequent renewal applications, the patient has previously demaintained adequate phenylalanine levels to support management  Patient continues to be pregnant and treatment with sapropterin weighted planning a pregnancy and this is the first renew appregnancy  Treatment with sapropterin is required for a second or subsequent pregnancy	ated an adequate response to a 2 to 4 week trial of levels to support management of PKU during pregnancy emonstrated response to treatment with sapropterin and t of PKU during pregnancy  ill not continue after delivery al for treatment with sapropterin pregnancy to support management of their PKU during se of 20 mg/kg		

I confirm that the above details are correct:	
Signed:	Date:

PRESCR	IBER	PATIENT:
Name:		Name:
Ward:		NHI:
Carglun	nic Acid	
INITIATIO Prerequi	ON isites (tick box where appropriate)	
	Prescribed by, or recommended by a metabolic physician, or in acconz Hospital.	ordance with a protocol or guideline that has been endorsed by the Health
and	For the acute in-patient treatment of organic acidaemias as an altern	native to haemofiltration

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:
Coenzyme Q10	
INITIATION Re-assessment required after 6 months Prerequisites (tick box where appropriate)  Prescribed by, or recommended by a metabolic physician, or in accommod NZ Hospital.  and  The patient has a suspected inborn error of metabolism that may re-	ordance with a protocol or guideline that has been endorsed by the Health spond to coenzyme Q10 supplementation
CONTINUATION  Re-assessment required after 24 months  Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a metabolic physician, or in accommod NZ Hospital.	ordance with a protocol or guideline that has been endorsed by the Health
The patient has a confirmed diagnosis of an inborn error of mand The treatment remains appropriate and the patient is benefiting	

Schedule. For community funding, see the Special Authority Criteria.	
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Riboflavin	
INITIATION Re-assessment required after 6 months Prerequisites (tick box where appropriate)  Prescribed by, or recommended by a metabolic physician or neurolog by the Health NZ Hospital.  and  The patient has a suspected inborn error of metabolism that may res	gist, or in accordance with a protocol or guideline that has been endorsed spond to riboflavin supplementation
CONTINUATION Re-assessment required after 24 months Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by a metabolic physician or neurolog by the Health NZ Hospital.	gist, or in accordance with a protocol or guideline that has been endorsed
The patient has a confirmed diagnosis of an inborn error of me and  The treatment remains appropriate and the patient is benefiting	

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Use this checklist to determine if a patient meets the restrictions for funding in Schedule. For community funding, see the Special Authority Criteria.	n the <b>hospital setting</b> . For more details, refer to Section H of the Pharmaceutical
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Taurine	
INITIATION Re-assessment required after 6 months Prerequisites (tick box where appropriate)  O Prescribed by, or recommended by a metabolic physician, or in ac NZ Hospital.  and O The patient has a suspected specific mitochondrial disorder that n	ecordance with a protocol or guideline that has been endorsed by the Health may respond to taurine supplementation
CONTINUATION Re-assessment required after 24 months Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a metabolic physician, or in act NZ Hospital.  and  The patient has a confirmed diagnosis of a specific mitocho and  The treatment remains appropriate and the patient is benefit	

I confirm that the above details are correct:

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

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PRESCRIBER		PATIENT:
Name:		Name:
Ward:		NHI:
Trientine		
O	(tick boxes where appropriate)  Patient has confirmed Wilson disease	
and	Treatment with D-penicillamine has been trialled and discontinued because the person has experienced intolerable side effects or has not received sufficient benefit  Treatment with zinc has been trialled and discontinued because the person has experienced intolerable side effects or has not received sufficient benefit, or zinc is considered clinically inappropriate as the person has symptomatic liver disease and requires copper chelation	

PRES	SCRIBER	PATIENT:
Name	2:	Name:
Ward:	:	NHI:
Cop	per chloride	
	ATION – Moderate to severe burns ssessment required after 3 months	
Prer	equisites (tick boxes where appropriate)	
	O Patient has been hospitalised with moderate to severe burns and	
	Treatment is recommended by a National Burns Unit specialis	st

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Ferric carboxymaltose	
INITIATION Prerequisites (tick box where appropriate)	
O Treatment with oral iron has proven ineffective or is clinically inappro	ppriate

PRES	CRIBER		PATIENT:
Name	e:		Name:
Ward:	:		NHI:
Sele	nium		
		Moderate to severe burns nt required after 3 months	
Prer	equisites	(tick boxes where appropriate)	
	and	Patient has been hospitalised with moderate to severe burns	
		Treatment is recommended by a National Burns Unit specialis	t

I confirm that the above details are correct:

Signed: Date:

#### Form RS1175 January 2025

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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PRESCRIBER		PATIENT:
Name:		Name:
Ward:		NHI:
Sodium hyaluronate		
INITIATION		
Prerequisites (tick box whe	ere appropriate)	
O Prescribed by, or Hospital.	recommended by an otolaryngologist, or in accord	ance with a protocol or guideline that has been endorsed by the Health NZ

PRESCRIBER				PATIENT:
Name	e:			Name:
Ward	:			NHI:
Mult	ivit	amir	ns - Cap	
INITI Prer			(tick boxes where appropriate)	
	<b>0</b> r	0	Patient has cystic fibrosis with pancreatic insufficiency	
	or	0	Patient is an infant or child with liver disease or short gut synd	rome
	01	$\circ$	Patient has severe malabsorption syndrome	

#### Form RS1178 January 2025

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 38

PATIENT:
Name:
NHI:

PRESCRIBER		PATIENT:
Name:		Name:
Ward:		NHI:
Multivitamiı	n and mineral supplement	
Prerequisites and	nt required after 3 months (tick boxes where appropriate)  Patient was admitted to hospital with burns  Burn size is greater than 15% of total body surface area	(BSA) for all types of burns
Of	O Burn size is greater than 10% of BSA for mid-dermal or	

Page 40

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:		
Multi	ivit	amir	renal			
INITIATION Prerequisites (tick boxes where appropriate)		(tick boxes where appropriate)				
	0	0	The patient has chronic kidney disease and is receiving either	peritoneal dialysis or haemodialysis		
	or O		The patient has chronic kidney disease grade 5, defined as pa body surface area (BSA)	atient with an estimated glomerular filtration rate of < 15 ml/min/1.73m <sup>2</sup>		

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Alpha tocop	pheryl acetate
	Cystic fibrosis (tick boxes where appropriate)
and _	Cystic fibrosis patient
	O Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck)
or	O The other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate for the patient
Prerequisites	Osteoradionecrosis (tick box where appropriate) he treatment of osteoradionecrosis
	Other indications (tick boxes where appropriate)
and and	Infant or child with liver disease or short gut syndrome Requires vitamin supplementation
	O Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplements (Vitabdeck)
or	O The other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate for patient

I confirm that the above details are correct:

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PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Alpha tocopheryl				
INITIATION – Cystic fibrosis Prerequisites (tick boxes where	appropriate)			
O Cystic fibrosis pa	tient			
	O Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck)			
The other the patient	available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate for			
INITIATION – Osteoradionecro Prerequisites (tick box where a	opropriate)			
INITIATION – Other indications Prerequisites (tick boxes where				
	h liver disease or short gut syndrome			
and Requires vitamin	supplementation			
O Patient has	s tried and failed the other available funded fat soluble vitamin A,D,E,K supplements (Vitabdeck)			
Or The other a patient	available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate for			

I confirm that the above details are correct:

Signed: Date:

### **Blood and Blood Forming Organs**



PRESCRIBER	PATIENT:
Name:	
Ward:	NHI:
Epoetin beta	a
	chronic renal failure (tick boxes where appropriate)
$\bigcap$	Patient in chronic renal failure
and and	Haemoglobin is less than or equal to 100g/L
	O Patient does not have diabetes mellitus and O Glomerular filtration rate is less than or equal to 30ml/min
or	O Patient has diabetes mellitus and
or	Glomerular filtration rate is less than or equal to 45ml/min
or	O Patient is on haemodialysis or peritoneal dialysis
Re-assessmer	myelodysplasia*  nt required after 12 months (tick boxes where appropriate)
and	Patient has a confirmed diagnosis of myelodysplasia (MDS)
and	Has had symptomatic anaemia with haemoglobin < 100g/L and is red cell transfusion-dependent
and	Patient has very low, low or intermediate risk MDS based on the WHO classification-based prognostic scoring system for myelodysplastic syndrome (WPSS)
O	Other causes of anaemia such as B12 and folate deficiency have been excluded
and	Patient has a serum epoetin level of < 500 IU/L
and	The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week
Re-assessmen	DN – myelodysplasia*  nt required after 2 months  (tick boxes where appropriate)
and	The patient's transfusion requirement continues to be reduced with epoetin treatment
and	Transformation to acute myeloid leukaemia has not occurred
	The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week

I confirm that the above details are correct:

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

PRES	CRIBER		PATIENT:		
Name	e:		Name:		
Ward	:		NHI:		
Еро	etin beta	a - continued			
INITIATION – all other indications					
Prerequisites (tick boxes where appropriate)		(tick boxes where appropriate)			
	O	Haematologist			
	and	For use in patients where blood transfusion is not a viable trea	atment alternative		
	and	*Note: Indications marked with * are unapproved indications			

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Signed.	Date:	
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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Epoetin alfa	
	chronic renal failure (tick boxes where appropriate)
and O	Patient in chronic renal failure  Haemoglobin is less than or equal to 100g/L
and	O Patient does not have diabetes mellitus and O Glomerular filtration rate is less than or equal to 30ml/min
or	Patient has diabetes mellitus  Glomerular filtration rate is less than or equal to 45ml/min  Patient is on haemodialysis or peritoneal dialysis
Re-assessmen	myelodysplasia* t required after 2 months (tick boxes where appropriate)
and	Patient has a confirmed diagnosis of myelodysplasia (MDS)
and	Has had symptomatic anaemia with haemoglobin < 100g/L and is red cell transfusion-dependent
and	Patient has very low, low or intermediate risk MDS based on the WHO classification-based prognostic scoring system for myelodysplastic syndrome (WPSS)
and	Other causes of anaemia such as B12 and folate deficiency have been excluded
and	Patient has a serum epoetin level of < 500 IU/L
O	The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week
Re-assessmen	ON – myelodysplasia* t required after 12 months (tick boxes where appropriate)
and	The patient's transfusion requirement continues to be reduced with epoetin treatment
and	Transformation to acute myeloid leukaemia has not occurred
	The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week

I confirm that the above details are correct:

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

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Epoetin alfa - continued			
INITIATION – all other indications Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
O For use in patients where blood transfusion is not a viable treatment Note: Indications marked with * are unapproved indications	alternative		

PRES	SCRI	IBER		PATIENT:			
Name	e:			Name:			
Ward	:			NHI:			
Apro	Aprotinin						
INITIATION Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a cardiac anaesthetist, or in accordance with a protocol or guideline that has been endorsed by the NZ Hospital.  and			ordance with a protocol or guideline that has been endorsed by the Health				
	Paediatric patient undergoing cardiopulmonary bypass procedure  O Adult patient undergoing cardiac surgical procedure where the significant risk of massive bleeding outweighs the potential ac						
			effects of the drug				

I confirm that the above details are correct:

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

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Eltrombopag			
Hospital.  Patient has had a splenectomy and  Two immunosuppressive therapies have been trialled and faile and  Patient has a platelet count of 20,000 to 30,000 platelets or	s per microlitre and has evidence of significant mucocutaneous bleeding  00 platelets per microlitre and has evidence of active bleeding		
INITIATION – idiopathic thrombocytopenic purpura - preparation for splenectomy Re-assessment required after 6 weeks Prerequisites (tick box where appropriate)  O Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  and  The patient requires eltrombopag treatment as preparation for splenectomy			
CONTINUATION – idiopathic thrombocytopenic purpura - post-splenector Re-assessment required after 12 months  Prerequisites (tick box where appropriate)	omy		
Prescribed by, or recommended by a haematologist, or in accordance Hospital.  and  The patient has obtained a response (see Note) from treatment during treatment is required  Note: Response to treatment is defined as a platelet count of > 30,000 platelet			
INITIATION – idiopathic thrombocytopenic purpura contraindicated to splenectomy Re-assessment required after 3 months Prerequisites (tick boxes where appropriate)			
Hospital.	e with a protocol or guideline that has been endorsed by the Health NZ		
or			

PRES	SCRIBER	PATIENT:
Name	:	Name:
Ward		NHI:
Eltro	mbopag - continued	
CONTINUATION – idiopathic thrombocytopenic purpura contraindicated to splenectomy Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Hospital.		
	The patient's significant contraindication to splenectomy remaind The patient has obtained a response from treatment during the and Patient has maintained a platelet count of at least 50,000 plate and Further treatment with eltrombopag is required to maintain re	ne initial approval period relets per microlitre on treatment
Re-a	Hospital.  Two immunosuppressive therapies have been trialled and fail  and  Patient has severe aplastic anaemia with a platelet cou	ed after therapy of at least 3 months duration  Int of less than or equal to 20,000 platelets per microliter  Int of 20,000 to 30,000 platelets per microlitre and significant
CONTINUATION – severe aplastic anaemia Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
and	The patient has obtained a response from treatment of at lead period  Platelet transfusion independence for a minimum of 8 weeks	st 20,000 platelets per microlitre above baseline during the initial approval during the initial approval period

I confirm that the above details are correct:		
Signed:	Date:	

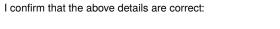
#### Form RS1500 January 2025

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 51

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:
Aluminium chloride	
INITIATION Prerequisites (tick box where appropriate)	
O For use as a haemostatis agent	



Signed: Date:

PRES	CRIBE	ER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Emic	cizum	nab		
INITIATION – Severe Haemophilia A with or without FVIII inhibitors  Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
and		) Pa		eding phenotype (endogenous factor VIII activity less than or equal to
	and		micizumab is to be administered at a dose of no greater than eekly	3 mg/kg weekly for 4 weeks followed by the equivalent of 1.5 mg/kg

I confirm that the above details are correct:		
Signed:	Date:	

#### Form RS1535 January 2025

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 53

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Idarucizumab	
INITIATION Prerequisites (tick box where appropriate)	
O For the reversal of the anticoagulant effects of dabigatran when required in situations of life-threatening or uncontrolled bleeding, or for emergency surgery or urgent procedures	

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Page 54

PRESCR	IBER	PATIENT:		
Name:		Name:		
Ward:		NHI:		
Moroctocog alfa [Recombinant factor VIII]				
INITIATION Prerequisites (tick box where appropriate)				
0	O For patients with haemophilia. Rare Clinical Circumstances Brand of short half-life recombinant factor VIII. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group, subject to criteria			

PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Octocog alfa [Recombinant factor VIII] (Advate)				
INITIATION				
Prerequisites (tick box where appropriate)				
O For patients with haemophilia. Preferred Brand of short half-life recombinant factor VIII. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group				

#### Form RS1708 January 2025

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 56

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Octocog alfa [Recombinant factor VIII] (Kogenate FS)			
INITIATION Prerequisites (tick box where appropriate)			
O For patients with haemophilia. Rare Clinical Circumstances Brand of short half-life recombinant factor VIII. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group, subject to criteria			
managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group, subject to criteria			

#### Form RS1679 January 2025

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 57

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Nonacog gamma	
INITIATION Prerequisites (tick box where appropriate)	
O For patients with haemophilia. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group	

I confirm that the above details are correct:		
Signed:	Date:	

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Rurioctocog alfa pegol [Recombinant factor VIII]		
INITIATION Prerequisites (tick box where appropriate)		
O For patients with haemophilia A receiving prophylaxis treatment. Ac in conjunction with the National Haemophilia Management Group	ccess to funded treatment is managed by the Haemophilia Treaters Group	

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Eftrenonacog alfa		
INITIATION		
Prerequisites (tick box where appropriate)		
O For patients with haemophilia B receiving prophylaxis treatment. Ac in conjunction with the National Haemophilia Management Group	cess to funded treatment is managed by the Haemophilia Treaters Group	

#### Form RS1705 January 2025

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 60

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:	
Factor eight inhibitor bypassing fraction		
INITIATION Prerequisites (tick box where appropriate)		
O For patients with haemophilia. Preferred Brand of bypassing agent for > 14 days predicted use. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group		

#### Form RS1704 January 2025

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 61

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Eptacog alfa	
INITIATION  Prerequisites (tick box where appropriate)  For patients with haemophilia. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group. Rare Clinical Circumstances Brand of bypassing agent for > 14 days predicted use. Access to funded treatment for > 14 days predicted use is by named patient application to the Haemophilia Treaters Group, subject to access criteria	

PRES	CR	RIBER	PATIENT:
Name	e:		Name:
Ward:	:		NHI:
Biva	liru	udin	
INITI Prere		ION uisites (tick boxes where appropriate)	
O For use in heparin-induced thrombocytopaenia, heparin resistance or heparin intolerance		tance or heparin intolerance	
	or	For use in patients undergoing endovascular procedures	

#### Form RS1182 January 2025

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 63

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:
Danaparoid	
INITIATION Prerequisites (tick box where appropriate)	
O For use in heparin-induced thrombocytopaenia, heparin resistance of	or heparin intolerance

I confirm that the above details are correct:

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Signed.	Date:	
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#### Form RS1183 January 2025

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 64

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Defibrotide		
INITIATION Prerequisites (tick box where appropriate)		
Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  and Patient has moderate or severe sinusoidal obstruction syndrome as a result of chemotherapy or regimen-related toxicities		

#### Form RS1184 January 2025

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 65

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:
Fondaparinux sodium	
INITIATION	
Prerequisites (tick box where appropriate)	
O For use in heparin-induced thrombocytopaenia, heparin resistance	or heparin intolerance

I confirm that the above details are correct:

Signed: Date:

PRES	CRIBER		PATIENT:
Name	):		Name:
Ward			NHI:
Lysi	ne acety	ylsalicylate	
	ATION equisites	(tick boxes where appropriate)	
For use when an immediate antiplatelet effect is required prior to an urgent interventional neuro-radiology or interven procedure		to an urgent interventional neuro-radiology or interventional cardiology	
	and	Administration of oral aspirin would delay the procedure	

PRES	SCR	IBER		PATIENT:
				Name:
				NHI:
Eptifibatide				
INITIATION Prerequisites (tick boxes where appropriate)				
	or	$\circ$	For use in patients with acute coronary syndromes undergoing	percutaneous coronary intervention
		0	For use in patients with definite or strongly suspected intra-coronary thrombus on coronary angiography	
	or	$\circ$	For use in patients undergoing intra-cranial intervention	

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.

PRES	SCRII	BER	PATIENT:
Name	ə:		Name:
Ward	:		NHI:
Tica	grel	or	
	O	<b>sites</b> Restr an S1	d to treatment of acute coronary syndromes specifically for patients who have recently (within the last 60 days) been diagnosed with evation or a non-ST-elevation acute coronary syndrome, and in whom fibrinolytic therapy has not been given in the last 24 hours and anned
Re-a	asses	smen	pmbosis prevention neurological stenting quired after 12 months k boxes where appropriate)
		or	Patient has had a neurological stenting procedure* in the last 60 days  Patient is about to have a neurological stenting procedure performed*
	and	or	Patient has demonstrated clopidogrel resistance using the P2Y12 (VerifyNow) assay or another appropriate platelet function assay and requires antiplatelet treatment with ticagrelor
			Clopidogrel resistance has been demonstrated by the occurrence of a new cerebral ischemic event  Clopidogrel resistance has been demonstrated by the occurrence of transient ischemic attack symptoms referable to the stent.
Re-a	asses	smen	- thrombosis prevention neurological stenting quired after 12 months k boxes where appropriate)
	and	0	tient is continuing to benefit from treatment eatment continues to be clinically appropriate
Re-a	asses	smen	cutaneous coronary intervention with stent deployment quired after 12 months c boxes where appropriate)
	and	$\circ$	tient has undergone percutaneous coronary intervention tient has had a stent deployed in the previous 4 weeks tient is clopidogrel-allergic**
	equi	sites	nt thrombosis  k box where appropriate) as experienced cardiac stent thrombosis whilst on clopidogrel
Re-a	equi:	smen sites	ccardial infarction quired after 1 week k box where appropriate) t term use while in hospital following ST-elevated myocardial infarction
I conf			pove details are correct:

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

#### Form RS1774 January 2025

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 69

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:

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: ......

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.

Ward:NHI:	PRESCRIBER		PATIENT:	
INITIATION – Autologous stem cell transplant Re-assessment required after 3 days Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Patient is to undergo stem cell transplantation and Patient has not had a previous unsuccessful mobilisation attempt with plerixafor and Patient is undergoing G-CSF mobilisation  Patient is undergoing G-CSF mobilisation  And Patient is undergoing G-CSF mobilisation  Patient is undergoing G-CSF mobilisation  Patient is undergoing G-CSF mobilisation  And Patient is undergoing G-CSF mobilisation  And Patient is undergoing chemotherapy and G-CSF mobilisation  Patient is undergoing chemotherapy and G-CSF mobilisation  Patient is undergoing chemotherapy and G-CSF mobilisation  And Patient is undergoing chemotherapy and G-CSF mobilisation  Patient is undergoing chemotherapy and G-CSF mobilisation  And Patient is undergoing chemotherapy and G-CSF mobilisation	Name:		Name:	
INITIATION – Autologous stem cell transplant Re-assessment required after 3 days Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Patient is to undergo stem cell transplantation and Patient has not had a previous unsuccessful mobilisation attempt with plerixafor and Patient is undergoing G-CSF mobilisation  Patient is undergoing G-CSF mobilisation  Autority of Patient is undergoing G-CSF mobilisation  Patient is undergoing G-CSF mobilisation  Autority of Patient is undergoing G-CSF mobilisation  Patient is undergoing chemotherapy and G-CSF mobilisation  Autority of Patient is undergoing chemotherapy and G-CSF mobilisation  Patient is undergoing chemotherapy and G-CSF mobilisation  Autority of Patient is undergoing chemotherapy and G-CSF mobilisation  Autority of Patient is undergoing chemotherapy and G-CSF mobilisation  Autority of Patient is undergoing chemotherapy and G-CSF mobilisation  Autority of Patient is undergoing chemotherapy and G-CSF mobilisation  Autority of Patient is undergoing chemotherapy and G-CSF mobilisation  Autority of Patient is undergoing chemotherapy and G-CSF mobilisation	Ward:		NHI:	
Re-assessment required after 3 days  Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Patient is to undergo stem cell transplantation  and  Patient has not had a previous unsuccessful mobilisation attempt with plerixafor  and  Patient is undergoing G-CSF mobilisation  Patient is undergoing G-CSF mobilisation  And  Patient is undergoing G-CSF mobilisation  Patient is undergoing G-CSF mobilisation  Or Efforts to collect > 1 × 10 <sup>6</sup> CD34 cells/kg have failed after one apheresis procedure  Or Patient is undergoing chemotherapy and G-CSF mobilisation  And  Has rising white blood cell counts of > 5 × 10 <sup>8</sup> /L	Plerixafor			
Or Efforts to collect > 1 × 10 <sup>6</sup> CD34 cells/kg have failed after one apheresis procedure or The peripheral blood CD34 cell counts are decreasing before the target has been received	Re-assessment required Prerequisites (tick boxes  Prescribed by, of Hospital.  and  Patient is and  and  or  or	after 3 days s where appropriate)  or recommended by a haematologist, or in accordance to undergo stem cell transplantation as not had a previous unsuccessful mobilisation atte  Patient is undergoing G-CSF mobilisation  Has a suboptimal peripheral blood CD34 contreatment  Efforts to collect > 1 × 10 <sup>6</sup> CD34 cells/kg has a suboptimal peripheral blood cell counts of and  Has a suboptimal peripheral blood CI  Or Has rising white blood cell counts of and  Has a suboptimal peripheral blood CI  Or Efforts to collect > 1 × 10 <sup>6</sup> CD34 cells/kg has a suboptimal peripheral blood CI  Or Efforts to collect > 1 × 10 <sup>6</sup> CD34 cells/kg has a suboptimal peripheral blood CI	mpt with plerixafor  bunt of less than or equal to $10 \times 10^6$ /L on day 5 after 4 days of G-CSF ave failed after one apheresis procedure  mobilisation  > $5 \times 10^9$ /L  D34 count of less than or equal to $10 \times 10^6$ /L  ave failed after one apheresis procedure	

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

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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.

eater than or equal to 5%*) pean Organisation for

I confirm that the above details are correct:

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

PRESCR	IBER	PATIENT:		
Name:		Name:		
Ward:		NHI:		
Filgrastim				
INITIATION				
Prerequisites (tick box where appropriate)				
0	O Prescribed by, or recommended by a haematologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Sodium chloride – Inj	
INITIATION Prerequisites (tick box where appropriate)	
O For use in flushing of in-situ vascular access devices only	

#### Cardiovascular System



PRES	SCR	IBER		PATIENT:	
Name	e:			Name:	
Ward	:			NHI:	
Capt	top	ril - C	Oral liq 5 mg per ml		
INITI			(tick boxes where appropriate)		
		0	For use in children under 12 years of age		
	or	0	For use in tube-fed patients		
	or	$\circ$	For management of rebound transient hypertension following	cardiac surgery	

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Signed.	Date:	
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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Sacubitril with valsartan	
INITIATION Prerequisites (tick boxes where appropriate)	
Patient has heart failure	
O Patient is in NYHA/WHO functional class II	
O Patient is in NYHA/WHO functional class III	
O Patient is in NYHA/WHO functional class IV	
and	
O Patient has a documented left ventricular ejection fracti	on (LVEF) of less than or equal to 35%
	n of the treating practitioner the patient would benefit from treatment
Patient is receiving concomitant optimal standard chronic hea	art failure treatments

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Adenosine - Inj 3 mg per ml, 10 ml vial	
INITIATION	`
Prerequisites (tick box where appropriate)	
O For use in cardiac catheterisation, electrophysiology and MRI	

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Signed.	Date:	
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PRESCRIBER	PATIENT:				
Name:	Name:				
Ward:	NHI:				
Ajmaline					
INITIATION	INITIATION				
Prerequisites (tick box where appropriate)					
O Prescribed by, or recommended by a cardiologist, or in accordar Hospital.	nce with a protocol or guideline that has been endorsed by the Health NZ				

PRES	CRIB	ER		PATIENT:
Name	:			Name:
Ward:				NHI:
lvabr	adin	ne		
INITI. Prere			(tick boxes where appropriate)	
	and	C	Patient is indicated for computed tomography coronary angiog	graphy
		or	O Patient has a heart rate of greater than 70 beats per min	nute while taking a maximally tolerated dose of beta blocker
O Patient is unable to tolerate beta blockers				

#### Form RS1427 January 2025

#### HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:
Midodrine	
INITIATION Prerequisites (tick box where appropriate)	
O Patient has disabling orthostatic hypotension not due to drugs	

I confirm that the above details are correct:

Signed: Date:

PRES	SCRI	IBER		PATIENT:
Name	e:			Name:
Ward:	:			NHI:
Nica	rdip	pine	hydrochloride	
INITIATION Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by an anaesthetist, intensivist, cardiologist or paediatric cardiologist.				ologist or paediatric cardiologist, or in accordance with a protocol or
and				ravenous agent
	or	$\bigcirc$	Patient has excessive ventricular afterload	
	.	0	Patient is awaiting or undergoing cardiac surgery using cardio	pulmonary bypass

PRES	CRIB	ER		PATIENT:
Name	:			Name:
Ward:				NHI:
Eple	reno	ne		
	ATION equisi		(tick boxes where appropriate)	
	and	C	Patient has heart failure with ejection fraction less than 40%	
		٥٢	O Patient is intolerant to optimal dosing of spironolactone	
	or		O Patient has experienced a clinically significant adverse e	effect while on optimal dosing of spironolactone

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Tolvaptan	
INITIATION – autosomal dominant polycystic kidney disease Re-assessment required after 12 months	
Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a renal physician or any relevant with a protocol or guideline that has been endorsed by the Health N.	t practitioner on the recommendation of a renal physician, or in accordance Z Hospital.
Patient has a confirmed diagnosis of autosomal dominant poly	/cystic kidney disease
O Patient has an estimated glomerular filtration rate (eGFR) of g	reater than or equal to 25 ml/min/1.73 m <sup>2</sup> at treatment initiation
	n eGFR of greater than or equal to 5 mL/min/1.73 m² within one-year
O Patient's disease is rapidly progressing, with an average year over a five-year period	e decline in eGFR of greater than or equal to 2.5 mL/min/1.73 m² per
CONTINUATION – autosomal dominant polycystic kidney disease Re-assessment required after 12 months	
Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a renal physician or any relevant with a protocol or guideline that has been endorsed by the Health N	t practitioner on the recommendation of a renal physician, or in accordance Z Hospital.
Patient has not developed end-stage renal disease, defined a	s an eGFR of less than 15 mL/min/1.73 m <sup>2</sup>
Patient has not undergone a kidney transplant	

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Oigilica.	 Duic.	

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.

PRESC	CRIBER	PATIENT:	
Name:	me: Name:		
Ward:		NHI:	
Rosu	vastati	n	
		cardiovascular disease risk (tick boxes where appropriate)	
	or an	O Patient is Māori or any Pacific ethnicity  O Patient has a calculated risk of cardiovascular disease of at least 15% over 5 years	
Prere		familial hypercholesterolemia (tick boxes where appropriate)  Patient has familial hypercholesterolemia (defined as a Dutch Lipid Criteria score greater than or equal to 6)  LDL cholesterol has not reduced to less than 1.8 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or simvastatin	
		established cardiovascular disease (tick boxes where appropriate)	
	or or	O Patient has proven coronary artery disease (CAD) O Patient has proven peripheral artery disease (PAD) O Patient has experienced an ischaemic stroke	
	O	LDL cholesterol has not reduced to less than 1.4 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or simvastatin	
		recurrent major cardiovascular events (tick boxes where appropriate)	
	and O	Patient has experienced a recurrent major cardiovascular event (defined as myocardial infarction, ischaemic stroke, coronary revascularisation, hospitalisation for unstable angina) in the last 2 years  LDL cholesterol has not reduced to less than 1.0 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or simvastatin	

I confirm that the above details are correct:

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

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Levosimendan		
INITIATION – Heart transplant Prerequisites (tick boxes where appropriate)		
O For use as a bridge to heart transplant, in patients who have been accepted for transplant O For the treatment of heart failure following heart transplant		
INITIATION – Heart failure Prerequisites (tick box where appropriate)		
O Prescribed by, or recommended by a cardiologist or intensivist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
O For the treatment of severe acute decompensated heart failure that	is non-responsive to dobutamine	

C:	D-1	
Signed.	Date:	
Oigilica.	 Duic.	

PRES	SCRIBER		PATIENT:
Name	ə:		Name:
Ward	:		NHI:
Alpr	ostadil		
	IATION equisites	(tick boxes where appropriate)	
	O	Patient has erectile dysfunction	
	and	Patient is to receive a penile Doppler ultrasonography	

PRES	SCR	IBER		PATIENT:
Name	e:			Name:
Ward	l:			NHI:
Hyd	rala	zine	hydrochloride - Tab 25 mg	
INIT Prer			(tick boxes where appropriate)	
		0	For the treatment of refractory hypertension	
O For the treatment of heart failure, in combination with a nitrate, in patients who are intolerant or have not responsand/or angiotensin receptor blockers		, in patients who are intolerant or have not responded to ACE inhibitors		

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:	
Nard:	NHI:
osentan	
O Prescribed	
Hospital.  O Patie	ent has pulmonary arterial hypertension (PAH)*
and	is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
or Or Or Or And	A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)  A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg  Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm <sup>-5</sup> )
and or or	Bosentan is to be used as PAH monotherapy  O Patient has experienced intolerable side effects on sildenafil O Patient has an absolute contraindication to sildenafil O Patient is a child with idiopathic PAH or PAH secondary to congenital heart disease

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:
Name:	
Vard:	NHI:
osentan - contin	ued
Prescribed a respirate Hospital.	
and PAH	I is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications  I is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV  O PAH has been confirmed by right heart catheterisation
aı	A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)  A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg  Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm <sup>-5</sup> )  PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †  Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**  Patient has PAH other than idiopathic / heritable or drug-associated type
or O	Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease  Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures
and	Bosentan is to be used as part of PAH dual therapy  Patient has tried a PAH monotherapy (sildenafil) for at least three months and has experienced an inadequate therapeutic response to treatment according to a validated risk stratification tool**  Patient is presenting in NYHA/WHO functional class III or IV, and in the opinion of the treating clinician would likely benefit from initial dual therapy

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.

SCRIBER	PATIENT:
e:	
l:	NHI:
entan - continue	ed
	rple therapy red after 6 months expess where appropriate)
	by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation o y specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
O Patier	nt has pulmonary arterial hypertension (PAH)*
O PAH is	s in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications
	s in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
and	O PAH has been confirmed by right heart catheterisation
and	A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)
and	A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg
anc	O Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm <sup>-5</sup> )
	PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †
	Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**
	O Patient has PAH other than idiopathic / heritable or drug-associated type
	Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease
	Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures
and	
and	Bosentan is to be used as part of PAH triple therapy
	O Patient is on the lung transplant list
or	O Patient is presenting in NYHA/WHO functional class IV
or	Patient has tried PAH dual therapy for at least three months and has not experienced an acceptable response to treatment according to a validated risk stratification tool**
	Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative

I confirm that the above details are correct:

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

#### Form RS1982 January 2025

#### HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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.

PRESCR	IBER	PATIENT:
Name:		Name:
Ward:		NHI:
bosenta	an - continued	
	IUATION ssment required after 2 years iisites (tick box where appropriate)	
and		gist, rheumatologist or any relevant practitioner on the recommendation of nice with a protocol or guideline that has been endorsed by the Health NZ rding to a validated PAH risk stratification tool**

Note: † The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the

diagnosis and treatment of pulmonary hypertension PAH

\*\* the requirement to use a validated risk stratification tool to determine insufficient response applies to adults.

Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

I confirm that the above details are correct: Signed: ...... Date: .....

RESCRIBE	₹	PATIENT:
lame:		Name:
Vard:		NHI:
mbrisent	an	
Re-assessm	- PAH monotherapy ent required after 6 month s (tick boxes where appr	
a re		ded by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of iologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and	Patient has pulmonary	v arterial hypertension (PAH)
and	PAH is in Group 1, 4 c	or 5 of the WHO (Venice 2003) clinical classifications
and	PAH is in New York He	eart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
	and A mean p and A pulmons and Pulmonar and O PAH defi or Pati or Patient is a child disorders includ	Deen confirmed by right heart catheterisation  ulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)  ary capillary wedge pressure (PCWP) less than or equal to 15 mmHg  y vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm <sup>-5</sup> )  If has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as need in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †  ent has not experienced an acceptable response to calcium antagonist treatment, according to a validated stratification tool**  ent has PAH other than idiopathic / heritable or drug-associated type  If with PAH secondary to congenital heart disease and elevated pulmonary pressures or a major complication of the secondary possible peart disease and elevated pulmonary pressures or a major complication of the secondary to congenital heart disease and elevated pulmonary pressures or a major complication of the
		ated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the on requiring the minimising of pulmonary/venous filling pressures
and	O Ambrisentan is	to be used as PAH monotherapy
	or Patient ha to current	s experienced intolerable side effects with both sildenafil and bosentan s an absolute contraindication to sildenafil and an absolute or relative contraindication to bosentan (e.g. due use of a combined oral contraceptive or liver disease) a child with idiopathic PAH or PAH secondary to congenital heart disease

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.

SCRIBER	PATIENT:
e:	
d:	NHI:
orisenta	n - continued
assessmer requisites O Pres	PAH dual therapy Introduce after 6 months Is (tick boxes where appropriate)  Incribed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation spiratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health Notial.
and	Patient has pulmonary arterial hypertension (PAH)
and	PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications
and	PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
	PAH has been confirmed by right heart catheterisation and
	O A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)
	A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg
	Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm <sup>-5</sup> )
	PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †
	Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**
	O Patient has PAH other than idiopathic / heritable or drug-associated type
or	O Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease
	O Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures
and	O Ambrisentan is to be used as PAH dual therapy
an	Patient has tried a PAH monotherapy (sildenafil or bosentan) for at least three months and has not experienced an acceptable response to treatment according to a validated risk stratification tool**
	O Patient has tried PAH dual therapy including bosentan and has experienced intolerable side effects on bosentan
an	and
	Patient is presenting in NYHA/WHO functional class III or IV, and in the opinion of the treating clinician would benefit from initial dual therapy
	Patient has an absolute or relative contraindication to bosentan (eg due to current use of a combined oral contraceptive or liver disease)

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.

	ER		PATIENT:
ne:			
d:			NHI:
briser	ntan	- con	tinued
assess	ment i	require	ple therapy ed after 6 months xes where appropriate)
а		ratory	y, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and	<b>О</b> F	Patient	t has pulmonary arterial hypertension (PAH)
and	) F	PAH is	in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications
and	O f	PAH is	in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
		and	O PAH has been confirmed by right heart catheterisation
		and	O A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)
		and	A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg
		and	O Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm <sup>-5</sup> )
			PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †
			O Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**
			O Patient has PAH other than idiopathic / heritable or drug-associated type
	or or	о О ғ	Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease  Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the
and		F	Fontan circulation requiring the minimising of pulmonary/venous filling pressures
and	and	O A	Ambrisentan is to be used as PAH triple therapy
		or	O Patient is on the lung transplant list
			O Patient is presenting in NYHA/WHO functional class IV and
			Patient has an absolute or relative contraindication to bosentan (e.g. due to current use of a combined oral contraceptive or liver disease)
		or	Patient has tried PAH dual therapy for at least three months and remains in an unacceptable risk category according to a validated risk stratification tool**
		T.	MIN _

I confirm that the above details are correct:

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

PRESCR	RIBER	PATIENT:
Name:		Name:
Ward:		NHI:
Ambris	entan - continued	
Re-asse	IUATION ssment required after 2 years ilisites (tick box where appropriate)	
and _		gist, rheumatologist or any relevant practitioner on the recommendation of nce with a protocol or guideline that has been endorsed by the Health NZ
0	The patient is continuing to derive benefit from ambrisentan treatme	nt according to a validated PAH risk stratification tool**

Note: † The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the

diagnosis and treatment of pulmonary hypertension PAH

\*\* the requirement to use a validated risk stratification tool to determine insufficient response applies to adults.

Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

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:
sildenafil (Veda	afil)
	ets Raynaud's Phenomenon k boxes where appropriate)
and Pat digi and Pat of s and Pat	tient has Raynaud's phenomenon  tient has severe digital ischaemia (defined as severe pain requiring hospital admission or with a high likelihood of digital ulceration; gital ulcers; or gangrene)  tient is following lifestyle management (proper body insulation, avoidance of cold exposure, smoking cessation support, avoidance sympathomimetic drugs)  tient has persisting severe symptoms despite treatment with calcium channel blockers and nitrates (unless contraindicated or not terated)
Prerequisites (tick	ets Pulmonary arterial hypertension k boxes where appropriate) ed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of tory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and PAH and and a	tient has pulmonary arterial hypertension (PAH)*  H is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications  H is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV  PAH is confirmed by right heart catheterisation  A mean pulmonary artery pressure (PAPm) of greater than 20 mmHg  and  A pulmonary capillary wedge pressure (PCWP) that is less than or equal to 15 mmHg  and  Pulmonary vascular resistance (PVR) of at least 2 Wood Units or at least 160 International Units (dyn s cm <sup>-5</sup> )  and  PAH is non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †  Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**  Patient has PAH other than idiopathic / heritable or drug-associated type  Patient has palliated single ventricle congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease  Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures

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.

PRES	CRIE	BER	PATIENT:
Name	e:		
Ward	·		NHI:
silde	nafi	I (V	edafil) - continued
			ablets other conditions (tick boxes where appropriate)  For use in weaning patients from inhaled nitric oxide
	or or	0	For perioperative use in cardiac surgery patients  For use in intensive care as an alternative to nitric oxide  For use in the treatment of erectile dysfunction secondary to spinal cord injury in patients being treated in a spinal unit
			njection (tick boxes where appropriate)
	and	0	For use in the treatment of pulmonary hypertension in infants or children being treated in paediatric intensive care units and neonatal intensive care units when the enteral route is not accessible
		or	O For perioperative use following cardiac surgery O For use in persistent pulmonary hypertension of the newborn (PPHN)
		or	O For use in congenital diaphragmatic hernia

Note: † The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the

diagnosis and treatment of pulmonary hypertension PAH

\*\* the requirement to use a validated risk stratification tool to determine insufficient response applies to adults.

Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Epoprostenol	
	ologist, rheumatologist or any relevant practitioner on the recommendation of dance with a protocol or guideline that has been endorsed by the Health NZ
Patient has pulmonary arterial hypertension (PAH)  and PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical and PAH is in New York Heart Association/World Health Organiand  PAH has been confirmed by right heart cathete and A mean pulmonary artery pressure (PAPm) greated and A pulmonary capillary wedge pressure (PCWP) and A pulmonary vascular resistance greater than 2 and  PAH has been demonstrated to be non-redefined in the 2022 ECS/ERS Guidelines	risation eater than 20 mmHg (unless peri Fontan repair) ester than or equal to 15 mmHg  2 Wood Units or greater than 160 International Units (dyn s cm <sup>-5</sup> ) esponsive in vasoreactivity assessment using iloprost or nitric oxide, as of or PAH (see note below for link to these guidelines) †  the response to calcium antagonist treatment, according to a validated
or  O Patient has palliated single ventricle congenital heart Fontan circulation requiring the minimising of pulmon and	disease and elevated pulmonary pressures or a major complication of the
Patient is presenting in NYHA/WHO functional class and	

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.

SCRIBER	PATIENT:
э:	Name:
!	NHI:
prostenol - co	ntinued
requisites (tick bo	ple therapy red after 6 months exes where appropriate)  by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health Na
and	t has pulmonary arterial hypertension (PAH)
PAH is	s in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications
O PAH is	s in New York Heart Association/World Health Organization (NYHA/WHO) functional class III or IV
and	O PAH has been confirmed by right heart catheterisation
and	A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)
and	A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg
and	A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm <sup>-5</sup> )
	PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †
	Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**
	O Patient has PAH other than idiopathic / heritable or drug-associated type
or	Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease  Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the
	Fontan circulation requiring the minimising of pulmonary/venous filling pressures
and and	Epoprostenol is to be used as PAH triple therapy
or	O Patient is on the lung transplant list O Patient is presenting in NYHA/WHO functional class IV
or	Patient has tried PAH dual therapy for at least three months and has not experienced an acceptable response to treatment according to a validated risk stratification tool
	O Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Epoprostenol - continued	
CONTINUATION Re-assessment required after 2 years Prerequisites (tick box where appropriate)	
a respiratory specialist, cardiologist or rheumatologist, or in accorda Hospital.	gist, rheumatologist or any relevant practitioner on the recommendation of ance with a protocol or guideline that has been endorsed by the Health NZ
Patient is continuing to derive benefit from epoprostenol treatment a	according to a validated PAH risk stratification tool

Note: † The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the

diagnosis and treatment of pulmonary hypertension PAH

\*\* the requirement to use a validated risk stratification tool to determine insufficient response applies to adults.

Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

I confirm that the above details are correct: Signed: ...... Date: .....

Name:  NHI:  nths propriate) ended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of rdiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ary arterial hypertension (PAH)
oropriate) ended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of rdiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
ended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of rdiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
ended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of rdiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
ry arterial hypertension (PAH)
or 5 of the WHO (Venice 2003) clinical classifications
Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair) mary capillary wedge pressure (PCWP) less than or equal to 15 mmHg mary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm <sup>-5</sup> )  AH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as fined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †  attent has not experienced an acceptable response to calcium antagonist treatment, according to a validated sk stratification tool**  attent has PAH other than idiopathic / heritable or drug-associated type
ild with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung iding severe chronic neonatal lung disease illiated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the tion requiring the minimising of pulmonary/venous filling pressures
e used as PAH monotherapy
nas experienced intolerable side effects on sildenafil and both the funded endothelin receptor antagonists (i.e. sentan and ambrisentan) nas an absolute contraindication to sildenafil and an absolute or relative contraindication to endothelin receptor
e na se

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.

CRIBER	PATIENT:		
	NHI:		
ost - contir	nued		
ATION – PA	H dual therapy equired after 6 months ck boxes where appropriate)		
	beed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation atory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health N.		
O P	atient has pulmonary arterial hypertension (PAH)		
O P	AH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications		
and P	AH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV		
	O PAH has been confirmed by right heart catheterisation		
	A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)		
	A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg and		
A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm <sup>-5</sup> )			
	PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †		
	Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**		
	O Patient has PAH other than idiopathic / heritable or drug-associated type		
or (	Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease		
	Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures		
and (	D lloprost is to be used as PAH dual therapy with either sildenafil or an endothelin receptor antagonist		
and	O Patient has an absolute contraindication to or has experienced intolerable side effects on sildenafil		
	O Patient has an absolute or relative contraindication to or experienced intolerable side effects with a funded endothelin receptor antagonist		
and			
	O Patient has tried a PAH monotherapy for at least three months and remains in an unacceptable risk category according to a validated risk stratification tool**		
	O Patient is presenting in NYHA/WHO functional class III or IV, and in the opinion of the treating clinician would benefit from initial dual therapy		

I confirm that the above details are correct:

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

SCRIBER	PATIENT:
ne:	
d:	NHI:
rost - continue	d
requisites (tick b	riple therapy irred after 6 months boxes where appropriate)  by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation or ry specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
Patie	ent has pulmonary arterial hypertension (PAH)
and	is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
an an an	A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)  d  A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg
an	PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †  Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**  Patient has PAH other than idiopathic / heritable or drug-associated type
or O	Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease  Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures
and O and or	Illoprost is to be used as PAH triple therapy  O Patient is on the lung transplant list O Patient is presenting in NYHAWHO functional class IV
or	Patient has tried PAH dual therapy for at least three months and has not experienced an acceptable response to treatment according to a validated risk stratification tool**  Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario

I confirm that the above details are correct:

Signed: Date:

Page 104

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.

PRESCR	IBER	PATIENT:		
Name:		Name:		
Ward:		NHI:		
lloprost	lloprost - continued			
	UATION ssment required after 2 years isites (tick box where appropriate)			
and		gist, rheumatologist or any relevant practitioner on the recommendation of nee with a protocol or guideline that has been endorsed by the Health NZ ing to a validated PAH risk stratification tool		

Note: † The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the

diagnosis and treatment of pulmonary hypertension PAH

\*\* the requirement to use a validated risk stratification tool to determine insufficient response applies to adults.

Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

I confirm that the above details are correct: Signed: ...... Date: .....

#### Dermatologicals

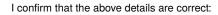


#### Form RS1299 January 2025

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 106

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Mafenide acetate	
INITIATION Prerequisites (tick box where appropriate)	
O For the treatment of burns patients	



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Signed.	Date:	
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PRESCI	RIBER	PATIENT:
Name:		Name:
Ward: .		NHI:
INITIAT		
Prereq	uisites (tick boxes where appropriate)	
	O For the treatment of intertrigo	
0	O For continuation use	

I confirm that the above details are correct:

Signed: Date:

Page 108

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.

PRES	CRIBE	ER		PATIENT:
Name	e:			Name:
Ward:	:			NHI:
Pime	Pimecrolimus			
INITIATION Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a dermatologist, paediatrician or ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
	and	) )	Patient has atopic dermatitis on the eyelid  Patient has at least one of the following contraindications to top epidermal atrophy, documented allergy to topical corticosteroic	pical corticosteroids: periorificial dermatitis, rosacea, documented ds, cataracts, glaucoma, or raised intraocular pressure

Page 109

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Tacrolimus Ointment	
INITIATION Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a dermatologist or paediatrician, Health NZ Hospital.	or in accordance with a protocol or guideline that has been endorsed by the
Patient has atopic dermatitis on the face	pical corticosteroids: periorificial dermatitis, rosacea, documented oids

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Methyl aminolevulinate hydrochloride			
INITIATION			
Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by a dermatologist or plastic surgeon, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			

#### **Genito-Urinary System**



#### Form RS1130 January 2025

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 112

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Terbutaline	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by an obstetrician, or in accordance Hospital.	e with a protocol or guideline that has been endorsed by the Health NZ

PRES	CRIB	ER		PATIENT:
Name	:			Name:
Ward:				NHI:
Finas	sterio	de		
	ATION equisi	-	(tick boxes where appropriate)	
	and	C	Patient has symptomatic benign prostatic hyperplasia	
O The patient is intolerant of non-selective alpha blockers or these are contraindicated or		or these are contraindicated		
		<u> </u>	O Symptoms are not adequately controlled with non-select	tive alpha blockers

PRES	CRIBER		PATIENT:	
Name:			Name:	
Ward:			NHI:	
Tam	sulosin			
INITIATION Prerequisites (tick boxes where appropriate)		(tick boxes where appropriate)		
	O	Patient has symptomatic benign prostatic hyperplasia		
	and	The patient is intolerant of non-selective alpha blockers or the	se are contraindicated	

I confirm that the above details are correct:

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Signed.	Date:	
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PRESCE	RIBER	PATIENT:	
Name:		Name:	
Ward:		NHI:	
Potass	sium citrate		
INITIATION Prerequisites (tick boxes where appropriate)			
aı	The patient has recurrent calcium oxalate urolithiasis  nd		
	The patient has had more than two renal calculi in the two year	urs prior to the application	

#### **Hormone Preparations**



#### Form RS1302 January 2025

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 117

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.

PATIENT:
Name:
NHI:

I confirm that the above details are correct:

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PRESCR	BER PATIENT:			
Name:				
Ward:	Nard:NHI:			
Cinacal	cet			
Re-asse	ON – parathyroid carcinoma or calciphylaxis sment required after 6 months sites (tick boxes where appropriate)  Prescribed by, or recommended by a nephrologist or endocrinologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  O The patient has been diagnosed with a parathyroid carcinoma (see Note) and O The patient has persistent hypercalcaemia (serum calcium greater than or equal to 3 mmol/L) despite previous first-line treatments including sodium thiosulfate (where appropriate) and bisphosphonates  The patient has been diagnosed with calciphylaxis (calcific uraemic arteriolopathy) and O The patient has symptomatic (e.g. painful skin ulcers) hypercalcaemia (serum calcium greater than or equal to 3 mmol/L)  The patient's condition has not responded to previous first-line treatments including bisphosphonates and sodium thiosulfate			
Prerequ and	O The patient has experienced clinically significant symptom improvement			
Note: Tr	is does not include parathyroid adenomas unless these have become malignant.			
	ON – primary hyperparathyroidism sites (tick boxes where appropriate)			
an	Patient has primary hyperparathyroidism  O Patient has hypercalcaemia of more than 3 mmol/L with or without symptoms O Patient has hypercalcaemia of more than 2.85 mmol/L with symptoms			
an	O Surgery is not feasible or has failed			

I confirm that the above details are correct:

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

PRES	CRIB	ER		PATIENT:
Name	:			Name:
Ward:				NHI:
Cina	calc	et -	- continued	
			secondary or tertiary hyperparathyroidism	
			(tick boxes where appropriate)	
				elevated parathyroid hormone (PTH) with hypercalcaemia
		or	O Patient has symptomatic secondary hyperparathyroidism	m and elevated PTH
and Patient is on renal replacement therapy				
	O Residual parathyroid tissue has not been localised despite repeat unsuccessful parathyroid explorations		pite repeat unsuccessful parathyroid explorations	
		or	O Parathyroid tissue is surgically inaccessible	
		OI .	O Parathyroid surgery is not feasible	
Re-a	ssess	men	DN – secondary or tertiary hyperparathyroidism tt required after 12 months (tick boxes where appropriate)	
	Or (	С	The patient has had a kidney transplant, and following a treat hormone (PTH) level to support ongoing cessation of treatme	ment free interval of at least 12 weeks a clinically acceptable parathyroid nt has not been reached
	<u>J,</u> (	<u> </u>	The patient has not received a kidney transplant and trial of w	vithdrawal of cinacalcet is clinically inappropriate
Re-a	and TINU	men	Patient is on renal replacement therapy  Residual parathyroid tissue has not been localised desponders.  Parathyroid tissue is surgically inaccessible.  Parathyroid surgery is not feasible.  Parathyroid surgery is not feasible.  Parathyroid surgery is not feasible.  DN – secondary or tertiary hyperparathyroidism at required after 12 months (tick boxes where appropriate).  The patient has had a kidney transplant, and following a treat hormone (PTH) level to support ongoing cessation of treatments.	ment free interval of at least 12 weeks a clinically acceptable parathyroid nt has not been reached

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Cabergoline	
INITIATION Prerequisites (tick boxes where appropriate)  O Inhibition of lactation	
or Patient has hyperprolactinemia or	
Note: Indication marked with * is an unapproved indication.	

I confirm that the above details are correct:

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Zigneg.	i jate:	
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#### RS1826 - Somatropin

Prader-Willi syndrome - INITIATION	125
Prader-Willi syndrome - CONTINUATION	
Turner syndrome - INITIATION	122
Turner syndrome - CONTINUATION	123
Adults and adolescents - INITIATION	126
Adults and adolescents - CONTINUATION	127
Growth hormone deficiency in children - INITIATION	122
Growth hormone deficiency in children - CONTINUATION	122
Short stature due to chronic renal insufficiency - INITIATION	124
Short stature due to chronic renal insufficiency - CONTINUATION	124
Short stature without growth hormone deficiency - INITIATION	
Short stature without growth hormone deficiency - CONTINUATION	123

PRES	CRI	IBER	P.	ATIENT:
Name	e:			ame:
Ward:	Ward:			HI:
Som	atro	opin		
Re-a	sses	ssmen	growth hormone deficiency in children nt required after 12 months (tick boxes where appropriate)	
and	С		cribed by, or recommended by an endocrinologist or paediatric encorsed by the Health NZ Hospital.	locrinologist, or in accordance with a protocol or guideline that has been
	or	0	Growth hormone deficiency causing symptomatic hypoglycaemia cardiomyopathy, hepatic dysfunction) and diagnosed with GH < 5 life, or from samples during established hypoglycaemia (whole bloom)	mcg/l on at least two random blood samples in the first 2 weeks of
		an	standards of Tanner and Davies (1985)	one age/pubertal status if appropriate over 6 or 12 months using the
		an	O A current bone age is < 14 years (female patients) or < 16 y	years (male patients)
		an	O Peak growth hormone value of < 5.0 mcg per litre in respor who are 5 years or older, GH testing with sex steroid primin	nse to two different growth hormone stimulation tests. In children g is required
			If the patient has been treated for a malignancy, they should laboratory and radiological imaging appropriate for the mali not necessary or appropriate	d be disease free for at least one year based upon follow-up gnancy, unless there are strong medical reasons why this is either
		an	Appropriate imaging of the pituitary gland has been obtained	d
Re-a	sses	ssmen isites Preso	ON – growth hormone deficiency in children nt required after 12 months (tick boxes where appropriate) cribed by, or recommended by an endocrinologist or paediatric encorsed by the Health NZ Hospital.	locrinologist, or in accordance with a protocol or guideline that has been
and	an	O	A current bone age is 14 years or under (female patients) or 16 y	rears or under (male patients)
	an	0	Height velocity is greater than or equal to 25th percentile for age hormone treatment, as calculated over six months using the standard control of the	(adjusted for bone age/pubertal status if appropriate) while on growth dards of Tanner and Davis (1985)
	an	$\circ$	Height velocity is greater than or equal to 2.0 cm per year, as calc	culated over 6 months
	an	$\circ$	No serious adverse effect that the patients specialist considers is	likely to be attributable to growth hormone treatment has occurred
		0	No malignancy has developed since starting growth hormone	
Re-a	sses	ssmen	Turner syndrome nt required after 12 months (tick boxes where appropriate)	
( and	О —		cribed by, or recommended by an endocrinologist or paediatric encorsed by the Health NZ Hospital.	locrinologist, or in accordance with a protocol or guideline that has been
	and	O	The patient has a post-natal genotype confirming Turner Syndron	ne
	an	$\circ$	Height velocity is < 25th percentile over 6-12 months using the sta	andards of Tanner and Davies (1985)
	411	O	A current bone age is < 14 years	
Lonfi	rm t	hat the	e above details are correct:	

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

I confirm that the above details are correct:

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

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRES	CRIBER	PATIENT:				
Name:						
Ward:	/ard:NHI:					
Soma	atropin	- continued				
CONT Re-as	FINUATION SEESTMENT PROPERTY OF THE PROPERTY O	ON – Turner syndrome Interequired after 12 months (tick boxes where appropriate)  Cribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been resed by the Health NZ Hospital.  Height velocity greater than or equal to 50th percentile for age (while on growth hormone calculated over 6 to 12 months using the Ranke's Turner Syndrome growth velocity charts)  Height velocity is greater than or equal to 2 cm per year, calculated over six months  A current bone age is 14 years or under				
	and O	No serious adverse effect that the specialist considers is likely to be attributable to growth hormone treatment has occurred  No malignancy has developed since starting growth hormone				
Re-as	ssessmer equisites Prese	short stature without growth hormone deficiency at required after 12 months (tick boxes where appropriate)  cribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been resed by the Health NZ Hospital.				
	and and and	The patient's height is more than 3 standard deviations below the mean for age or for bone age if there is marked growth acceleration or delay  Height velocity is < 25th percentile for age (adjusted for bone age/pubertal status if appropriate), as calculated over 6 to 12 months using the standards of Tanner and Davies(1985)  A current bone age is < 14 years (female patients) or < 16 years (male patients)  The patient does not have severe chronic disease (including malignancy or recognized severe skeletal dysplasia) and is not receiving medications known to impair height velocity				
Re-as	ssessmer equisites Prese	ON – short stature without growth hormone deficiency at required after 12 months (tick boxes where appropriate)  cribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been rised by the Health NZ Hospital.				
	and on and on and	Height velocity is greater than or equal to 50th percentile (adjusted for bone age/pubertal status if appropriate) as calculated over 6 to 12 months using the standards of Tanner and Davies (1985)  Height velocity is greater than or equal to 2 cm per year as calculated over six months  Current bone age is 14 years or under (female patients) or 16 years or under (male patients)  No serious adverse effect that the patient's specialist considers is likely to be attributable to growth hormone treatment has occurred				

	R F	ATIENT:
Name:	N	lame:
Ward:	N	HI:
Somatropir	1 - continued	
Re-assessme Prerequisites  Pres	eshort stature due to chronic renal insufficiency ent required after 12 months s (tick boxes where appropriate) scribed by, or recommended by an endocrinologist, paediatric endocaediatric endocrinologist, or in accordance with a protocol or guide  The patient's height is more than 2 standard deviations below the	
and and and and and	Height velocity is < 25th percentile (adjusted for bone age/puber standards of Tanner and Davies (1985)  A current bone age is to 14 years or under (female patients) or to the patient is metabolically stable, has no evidence of metabolically the patient is under the supervision of a specialist with expertises.  The patient has a GFR less than or equal to 30 ml/min/1.7 creatinine (umol/l × 40 = corrected GFR (ml/min/1.73 m²)	tal status if appropriate) as calculated over 6 to 12 months using the o 16 years or under (male patients)  bone disease and absence of any other severe chronic disease in renal medicine  3 m² as measured by the Schwartz method (Height(cm)/plasma
CONTINUATI	ON – short stature due to chronic renal insufficiency	
Re-assessme	ent required after 12 months	
O Pres		
and	aediatric endocrinologist, or in accordance with a protocol or guide	ocrinologist or renal physician on the recommendation of a endocrinologist line that has been endorsed by the Health NZ Hospital.

I confirm that the above details are correct:

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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:
Somatropin -	continued
INITIATION – Properties (times and and and and and and assessment or prescription of the properties (times and	ader-Willi syndrome required after 12 months ck boxes where appropriate)  bed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been ed by the Health NZ Hospital.  The patient has a diagnosis of Prader-Willi syndrome that has been confirmed by genetic testing or clinical scoring criteria  The patient is aged six months or older  A current bone age is < 14 years (female patients) or < 16 years (male patients)  Sleep studies or overnight oximetry have been performed and there is no obstructive sleep disorder requiring treatment, or if an obstructive sleep disorder is found, it has been adequately treated under the care of a paediatric respiratory physician and/or ENT urgeon  The patient is aged two years or older  There is no evidence of type II diabetes or uncontrolled obesity defined by BMI that has increased by greater than or equal to 0.5 standard deviations in the preceding 12 months  The patient is aged between six months and two years and a thorough upper airway assessment is planned to be undertaken prior to treatment commencement and at six to 12 weeks following treatment initiation
Re-assessment representations (time of the present endors) and the presentation of the	I - Prader-Willi syndrome required after 12 months lock boxes where appropriate) bed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been ed by the Health NZ Hospital.  Height velocity is greater than or equal to 50th percentile (adjusted for bone age/pubertal status if appropriate) as calculated over 6 to 2 months using the standards of Tanner and Davies (1985)  Height velocity is greater than or equal to 2 cm per year as calculated over six months  A current bone age is 14 years or under (female patients) or 16 years or under (male patients)  No serious adverse effect that the patient's specialist con siders is likely to be attributable to growth hormone treatment has occurred and malignancy has developed after growth hormone therapy was commenced  The patient has not developed type II diabetes or uncontrolled obesity as defined by BMI that has increased by greater than or equal to 0.5 standard deviations in the preceding 12 months

I confirm that the above details are correct:

Signed: Date:

al

		PATIENT:
ame:		Name:
ard:		NHI:
omatropin - cor	ntinued	
	s and adolescents	
	uired after 12 months coxes where appropriate)	
	by, or recommended by an endocrinologist by the Health NZ Hospital.	or paediatric endocrinologist, or in accordance with a protocol or guideline that has been
O The	patient has a medical condition that is know ment of a pituitary tumour)	n to cause growth hormone deficiency (e.g. surgical removal of the pituitary for
O The	patient has undergone appropriate treatmer	nt of other hormonal deficiencies and psychological illnesses
	patient has severe growth hormone deficien	cy (see notes)
	patient's serum IGF-I is more than 1 standa	rd deviation below the mean for age and sex
	patient has poor quality of life, as defined by th hormone deficiency (QoL-AGHDA®)	a score of 16 or more using the disease-specific quality of life questionnaire for adult
solated growth horn n additional test is he dose of somatro or age and sex; and	more additional anterior pituitary hormone of none deficiency require two growth hormone required, an arginine provocation test can be upin should be started at 0.2 mg daily and be	e used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litri e titrated by 0.1 mg monthly until it is within 1 standard deviation of the mean normal va
solated growth horn in additional test is the dose of somatro or age and sex; and the dose of somatro	more additional anterior pituitary hormone of none deficiency require two growth hormone required, an arginine provocation test can be up in should be started at 0.2 mg daily and be up in not to exceed 0.7 mg per day for male p	leficiencies and a known structural pituitary lesion only require one test. Patients with stimulation tests, of which, one should be ITT unless otherwise contraindicated. When sused with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre
solated growth horn in additional test is the dose of somatro or age and sex; and the dose of somatro t the commenceme	more additional anterior pituitary hormone of none deficiency require two growth hormone required, an arginine provocation test can be up in should be started at 0.2 mg daily and be up in not to exceed 0.7 mg per day for male p	deficiencies and a known structural pituitary lesion only require one test. Patients with a stimulation tests, of which, one should be ITT unless otherwise contraindicated. Where used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre at titrated by 0.1 mg monthly until it is within 1 standard deviation of the mean normal valuations, or 1 mg per day for female patients.
solated growth horn in additional test is the dose of somatro or age and sex; and the dose of somatro t the commenceme	more additional anterior pituitary hormone of none deficiency require two growth hormone required, an arginine provocation test can be up in should be started at 0.2 mg daily and be up in not to exceed 0.7 mg per day for male p	deficiencies and a known structural pituitary lesion only require one test. Patients with a stimulation tests, of which, one should be ITT unless otherwise contraindicated. Where used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre at titrated by 0.1 mg monthly until it is within 1 standard deviation of the mean normal valuations, or 1 mg per day for female patients.
solated growth horn in additional test is the dose of somatro or age and sex; and the dose of somatro t the commenceme	more additional anterior pituitary hormone of none deficiency require two growth hormone required, an arginine provocation test can be up in should be started at 0.2 mg daily and be up in not to exceed 0.7 mg per day for male p	deficiencies and a known structural pituitary lesion only require one test. Patients with a stimulation tests, of which, one should be ITT unless otherwise contraindicated. Where used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litrice titrated by 0.1 mg monthly until it is within 1 standard deviation of the mean normal valuations, or 1 mg per day for female patients.
solated growth horn in additional test is the dose of somatro or age and sex; and the dose of somatro t the commenceme	more additional anterior pituitary hormone of none deficiency require two growth hormone required, an arginine provocation test can be up in should be started at 0.2 mg daily and be up in not to exceed 0.7 mg per day for male p	deficiencies and a known structural pituitary lesion only require one test. Patients with a stimulation tests, of which, one should be ITT unless otherwise contraindicated. Where used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litred titrated by 0.1 mg monthly until it is within 1 standard deviation of the mean normal valuations, or 1 mg per day for female patients.

I confirm that the above details are correct:

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Signed.	Date:	
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PRES	CRII	BER	PATIENT:	
Name	):			
Ward	:		NHI:	
Som	atro	pin - cor	continued	
Re-a	sses: equis	sment requ sites (tick b	<ul> <li>adults and adolescents</li> <li>equired after 12 months</li> <li>ck boxes where appropriate)</li> <li>bed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guide</li> </ul>	eline that has been
and		endorsed b	ed by the Health NZ Hospital.	
		and	The patient has been treated with somatropin for < 12 months	
		and	There has been an improvement in the Quality of Life Assessment defined as a reduction of at least 8 points on Life Assessment of Growth Hormone Deficiency in Adults (QoL-AGHDA®) score from baseline	the Quality of
		and	Serum IGF-I levels have increased to within ±1SD of the mean of the normal range for age and sex	
		O	The dose of somatropin does not exceed 0.7 mg per day for male patients, or 1 mg per day for female patients	
	or			
		and	The patient has been treated with somatropin for more than 12 months	
		and	The patient has not had a deterioration in Quality of Life defined as a 6 point or greater increase from their lowes score on treatment (other than due to obvious external factors such as external stressors)	t QoL-AGHDA®
		and	Serum IGF-I levels have continued to be maintained within ±1SD of the mean of the normal range for age and se for obvious external factors)	ex (other than
			The dose of somatropin has not exceeded 0.7 mg per day for male patients or 1 mg per day for female patients	
			The patient has had a Special Authority approval for somatropin for childhood deficiency in children and no longer renewal criteria under this indication  The patient has undergone appropriate treatment of other hormonal deficiencies and psychological illnesses  The patient has severe growth hormone deficiency (see notes)  The patient's serum IGF-I is more than 1 standard deviation below the mean for age and sex  The patient has poor quality of life, as defined by a score of 16 or more using the disease-specific quality of life of for adult growth hormone deficiency (QoL-AGHDA®)  The poses of adults and adolescents, severe growth hormone deficiency is defined as a peak serum growth hormone lever litre during an adequately performed insulin tolerance test (ITT) or glucagon stimulation test.	questionnaire
Patie isola an ad The mean The At th	ents wated good dotself and the dose dose dose dose dose dose dose dos	vith one or rowth horm nal test is a of somatro mal value f of somatro	or more additional anterior pituitary hormone deficiencies and a known structural pituitary lesion only require one test ormone deficiency require two growth hormone stimulation tests, of which, one should be ITT unless otherwise control is required, an arginine provocation test can be used with a peak serum growth hormone level of less than or equal that atropin should be started at 0.2 mg daily and be titrated by 0.1 mg monthly until the serum IGF-I is within 1 standard use for age and sex; and atropin not to exceed 0.7 mg per day for male patients, or 1 mg per day for female patients.	aindicated. Where o 0.4 mcg per litre. deviation of the
I confi	rm th	at the abov	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:
Liothyronine sodium - Tab 20 mcg	
INITIATION Prerequisites (tick box where appropriate)	
O For a maximum of 14 days' treatment in patients with thyroid cancer	who are due to receive radioiodine therapy

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	. NHI:
Propylthiouracil	
INITIATION Prerequisites (tick boxes where appropriate)	
O The patient has hyperthyroidism	
The patient is intolerant of carbimazole or carbimazole is co	ntraindicated

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Signed.	Date:	
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#### Infections



PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Streptomycin sulphate			
INITIATION			
Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			

#### Form RS1041 January 2025

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 132

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Amikacin			
INITIATION			
Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Tobramycin			
INITIATION			
Prerequisites (tick box where appropriate)			
Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			

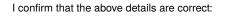
PATIENT:
Name:
NHI:

#### Form RS1475 January 2025

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 135

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Tobramcyin	
INITIATION Prerequisites (tick box where appropriate)	
O For addition to orthopaedic bone cement	



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Signed.	Date:	
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PRESCRIBER	PATIENT:	
Name:	. Name:	
Ward:	. NHI:	
Paromomycin		
INITIATION Prerequisites (tick box where appropriate)		
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or gastroenterologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Imipenem with cilastatin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

#### Form RS1045 January 2025

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 138

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Ertapenem	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infect been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

#### Form RS1047 January 2025

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 139

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Meropenem			
INITIATION			
Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has		

#### Form RS1048 January 2025

#### HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 140

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Ceftazadime	
INITIATION  Prerequisites (tick box where appropriate)	
Prescribed by, or recommended by a clinical microbiologist, infection protocol or guideline that has been endorsed by the Health NZ Hosp	us disease specialist or respiratory specialist, or in accordance with a pital.

#### Form RS1049 January 2025

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 141

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Cefepime			
INITIATION			
Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by a clinical microbiologist or infect been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has		

Page 142

PRESCRIBER				PATIENT:		
Name	e:			Name:		
Ward:				NHI:		
Cefta	arol	ine				
INITIATION – multi-resistant organisn salvage therapy Prerequisites (tick boxes where appropriate)						
and	Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.					
	or	0	For patients where alternative therapies have failed			
	O For patients who have a contraindication or hypersensitivity to standard current therapies					

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Roxithromycin tab dispersible 50 mg	
INITIATION Prerequisites (tick box where appropriate)	
O Only for use in patients under 12 years of age	

PRES	CRIBER	PATIENT:		
Name	:	Name:		
Ward		NHI:		
Clari	thromycin			
	ATION – Tab 250 mg and oral liquid equisites (tick boxes where appropriate)			
	Atypical mycobacterial infection  Mycobacterium tuberculosis infection where there is drug res  Helicobacter pylori eradication  Prophylaxis of infective endocarditis associated with surgical			
INITIATION – Tab 500 mg Prerequisites (tick box where appropriate)  O Helicobacter pylori eradication				
INITIATION – Infusion Prerequisites (tick boxes where appropriate)				
	O Atypical mycobacterial infection O Mycobacterium tuberculosis infection where there is drug res O Community-acquired pneumonia	istance or intolerance to standard pharmaceutical agents		

C:	D-1	
Signed.	Date:	
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I confirm that the above details are correct:

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

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:
ame: Name:	
Ward:	NHI:
Azithromycin	
INITIATION – bronchiolitis obliterans syndrome, cystic fibrosis and atype Prerequisites (tick boxes where appropriate)	oical Mycobacterium infections
or O Patient has received a lung transplant and requires prophylax or	bone marrow transplant and requires treatment for bronchiolitis  dis for bronchiolitis obliterans syndrome*  adomonas aeruginosa or Pseudomonas related gram negative organisms*
INITIATION – non-cystic fibrosis bronchiectasis* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a respiratory specialist or paedi endorsed by the Health NZ Hospital.  To prophylaxis of exacerbations of non-cystic fibrosis bronch and  Patient is aged 18 and under	ilectasis*
Patient has had 3 or more exacerbations of their bronch or  Patient has had 3 acute admissions to hospital for treat  Note: Indications marked with * are unapproved indications. A maximum of 2 in the community.	ment of infective respiratory exacerbations within a 12 month period
CONTINUATION – non-cystic fibrosis bronchiectasis* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a respiratory specialist or paedi endorsed by the Health NZ Hospital.  and  The patient has completed 12 months of azithromycin treatment and  Following initial 12 months of treatment, the patient has not repronchiectasis for a further 12 months, unless considered clirand  The patient will not receive more than a total of 24 months' azin the community.  Note: Indications marked with * are unapproved indications. A maximum of 2 in the community.  INITIATION – other indications Re-assessment required after 5 days	ent for non-cystic fibrosis bronchiectasis ecceived any further azithromycin treatment for non-cystic fibrosis nically inappropriate to stop treatment zithromycin cumulative treatment (see note)
Prerequisites (tick box where appropriate)  For any other condition	

#### Form RS1598 January 2025

### HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 146

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Azithromycin - continued	
CONTINUATION – other indications Re-assessment required after 5 days	
Prerequisites (tick box where appropriate)	
O For any other condition	



PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Ticarcillin with clavulanic acid		
INITIATION		
Prerequisites (tick box where appropriate)		
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Piperacillin with tazobactam	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, infection protocol or quideline that has been endorsed by the Health NZ Host	us disease specialist or respiratory specialist, or in accordance with a

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Ciprofloxacin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infect been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

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.

PRES	CRIB	ER	PATIENT:
Name:			
Ward:			NHI:
Moxi	floxa	acin	
	quisi	i <b>tes</b> (1 Prescr	ycobacterium infection ick boxes where appropriate) ibed by, or recommended by an infectious disease specialist, clinical microbiologist or respiratory specialist, or in accordance with a ol or guideline that has been endorsed by the Health NZ Hospital.
		and	O Active tuberculosis  O Documented resistance to one or more first-line medications
INITIA	or (	C	Suspected resistance to one or more first-line medications (tuberculosis assumed to be contracted in an area with known resistance), as part of regimen containing other second-line agents  Impaired visual acuity (considered to preclude ethambutol use)  Significant pre-existing liver disease or hepatotoxicity from tuberculosis medications  Significant documented intolerance and/or side effects following a reasonable trial of first-line medications  Mycobacterium avium-intracellulare complex not responding to other therapy or where such therapy is contraindicated  Patient is under five years of age and has had close contact with a confirmed multi-drug resistant tuberculosis case
	quisi	i <b>tes</b> (1 Prescr	ick boxes where appropriate)  ibed by, or recommended by an infectious disease specialist or clinical microbiologist, or in accordance with a protocol or guideline that en endorsed by the Health NZ Hospital.
	or (	$\sim$	mmunocompromised patient with pneumonia that is unresponsive to first-line treatment  Pneumococcal pneumonia or other invasive pneumococcal disease highly resistant to other antibiotics
1			enetrating eye injury ick box where appropriate)
and	\ \	łospit	ibed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ al.  ays treatment for patients requiring prophylaxis following a penetrating eye injury
			ycoplasma genitalium ick boxes where appropriate)
	and	or	Has nucleic acid amplification test (NAAT) confirmed Mycoplasma genitalium and is symptomatic  Has tried and failed to clear infection using azithromycin  Has laboratory confirmed azithromycin resistance
Loopfir	m tha		above details are correct:

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

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Tigecycline	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infection been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Daptomycin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Lincomycin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infect been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

#### Form RS1066 January 2025

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 154

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Linezolid	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infect been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Sulphadiazine	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or maternal-foetal medicine specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

#### Form RS1068 January 2025

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 156

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Teicoplanin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infection been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

#### Form RS1315 January 2025

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 157

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Fosfomycin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infect been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pivmecillinam	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

#### Form RS1069 January 2025

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 159

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:
Vancomycin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infection been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Aztreonam, Chloramphenicol	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Clindamycin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infect been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

#### Form RS1064 January 2025

### HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 162

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:
Fusidic acid	
INITIATION Prerequisites (tick box where appropriate)	
Prescribed by, or recommended by a clinical microbiologist or infect been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Colistin sulphomethate [Colestimethate]		
INITIATION Prerequisites (tick box where appropriate)		
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		

Page 164

PRESCR	IBER	PATIENT:
Name:		Name:
Ward:		NHI:
Ketoco	nazole - Tab 200 mg	
INITIATION Prerequisites (tick box where appropriate)		
Frerequ	isites (tick box where appropriate)	
	Prescribed by, or recommended by an oncologist, or in accordance Hospital.	with a protocol or guideline that has been endorsed by the Health NZ

PRES	CRIE	BER		PATIENT:
Name	:			Name:
Ward:				NHI:
Amp	hote	ericin I	3 - Inj (liposomal) 50 mg vial	
INITI Prero	equis	sites (tick	c boxes where appropriate) ed by, or recommended by a clinical microbiologist, haemat at specialist, or in accordance with a protocol or guideline th	ologist, infectious disease specialist, oncologist, respiratory specialist or at has been endorsed by the Health NZ Hospital.
	or	O Pro	Possible invasive fungal infection, to be prescribed  Possible invasive fungal infection  A multidisciplinary team (including an infectious disease appropriate	e physician or a clinical microbiologist) considers the treatment to be

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Zigneg.	i jate:	
Oigilica.	 Duic.	

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Amphotericin B - Inj 50 mg vial		
INITIATION		
Prerequisites (tick box where appropriate)		
O Prescribed by, or recommended by a clinical microbiologist, haematologist, infectious disease specialist, oncologist, respiratory specialist or transplant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		

#### Form RS1072 January 2025

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 167

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Fluconazole	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a consultant, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

#### Form RS1073 January 2025

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 168

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Itraconazole	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical immunologist, clinical r with a protocol or guideline that has been endorsed by the Health N	microbiologist, dermatologist or infectious disease specialist, or in accordance Z Hospital.

I confirm that the above details are correct:

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

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Voriconazole	
INITIATION – Proven or probable aspergillus infection Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, haema guideline that has been endorsed by the Health NZ Hospital.	atologist or infectious disease specialist, or in accordance with a protocol or
Patient is immunocompromised and Patient has proven or probable invasive aspergillus infection	
INITIATION – Possible aspergillus infection Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, haema guideline that has been endorsed by the Health NZ Hospital.	atologist or infectious disease specialist, or in accordance with a protocol or
O Patient is immunocompromised	
Patient has possible invasive aspergillus infection	
A multidisciplinary team (including an infectious disease physical)	sician) considers the treatment to be appropriate
INITIATION – Resistant candidiasis infections and other moulds  Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by a clinical microbiologist, haema guideline that has been endorsed by the Health NZ Hospital.	ttologist or infectious disease specialist, or in accordance with a protocol or
O Patient is immunocompromised and	
O Patient has fluconazole resistant candidiasis or	
O Patient has mould strain such as Fusarium spp. and S	cedosporium spp
A multidisciplinary team (including an infectious disease physical)	sician or clinical microbiologist) considers the treatment to be appropriate
INITIATION – Invasive fungal infection prophylaxis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by any relevant practitioner, or in a NZ Hospital.	accordance with a protocol or guideline that has been endorsed by the Health
O The patient is at risk of invasive fungal infection and	
Voriconazole is prescribed by, or recommended by a h paediatric haematologist or paediatric oncologist	aematologist, transplant physician, infectious disease specialist,
O Prescribing voriconazole is in accordance with a protoc	col or guideline that has been endorsed by the Health New Zealand - Te e is a greater than 10% risk of invasive fungal infection (IFI)

PRES	CRIB	BER			PATIENT:
Name	:				Name:
Ward:					NHI:
Vorio	ona	zol	<b>e</b> - cc	ontinued	
Re-a	ssess <b>equis</b> Э	men ites Presc	t requ (tick b		cordance with a protocol or guideline that has been endorsed by the Health
	and	0	The p	patient is at risk of invasive fungal infection	
		or	0	paediatric haematologist or paediatric oncologist	ematologist, transplant physician, infectious disease specialist,
					of or guideline that has been endorsed by the Health New Zealand - Te s a greater than 10% risk of invasive fungal infection (IFI)

January 2025

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:			
Posaconazole				
INITIATION Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate)  Or Prescribed by, or recommended by a haematologist or infectious discendorsed by the Health NZ Hospital.  Or Patient has acute myeloid leukaemia or Or Patient is planned to receive a stem cell transplant and it and Or Patient is to be treated with high dose remission induction their				
CONTINUATION Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a haematologist or infectious disendorsed by the Health NZ Hospital.  and  O Patient has previously received posaconazole prophylaxis durand  O Patient is to be treated with high dose remission re-induror  O Patient is to be treated with high dose consolidation there or  O Patient is receiving a high risk stem cell transplant	ction therapy			
NZ Hospital.  The patient is at risk of invasive fungal infection and  Posaconazole is prescribed by, or recommended by a h paediatric haematologist or paediatric oncologist  Prescribing posaconazole is in accordance with a protocologist.	ecordance with a protocol or guideline that has been endorsed by the Health aematologist, transplant physician, infectious disease specialist, col or guideline that has been endorsed by the Health New Zealand - Te is a greater than 10% risk of invasive fungal infection (IFI)			

I confirm that the above details are correct:

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Signeg.	 Date:	
Cigiloa.	 Date.	

RIB	ER			PATIENT:
				Name:
				NHI:
ona	azol	<b>e</b> - c	continued	
sessr <b>quisi</b> ) P	ment <b>tes</b> (	requitick b	ired after 6 months oxes where appropriate) by, or recommended by any relevant practitioner, or in ac	cordance with a protocol or guideline that has been endorsed by the Health
and	)	The p	patient is at risk of invasive fungal infection	
	or	0	Posaconazole is prescribed by, or recommended by a hapaediatric haematologist or paediatric oncologist	aematologist, transplant physician, infectious disease specialist,
0.	υ <sub>1</sub>	0		ol or guideline that has been endorsed by the Health New Zealand - Te s a greater than 10% risk of invasive fungal infection (IFI)
	inu/sessi	inuation sessment quisites (	conazole - consistent requipulsites (tick by Prescribed NZ Hospita	INUATION – Invasive fungal infection prophylaxis sessment required after 6 months quisites (tick boxes where appropriate)  Prescribed by, or recommended by any relevant practitioner, or in activity NZ Hospital.  The patient is at risk of invasive fungal infection  Posaconazole is prescribed by, or recommended by a har paediatric haematologist or paediatric oncologist  Prescribing posaconazole is in accordance with a protocologist

I confirm that the above details are correct:	
Cianadi	Data

Page 173

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Flucytosine			
INITIATION			
Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by a clinical microbiologist or infect been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has		

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.

Name:  Ward:  NHI:  NHI:  Caspofungin  INITIATION  Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a clinical microbiologist, haematologist, infectious disease specialist, oncologist, respiratory specialist or transplant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Proven or probable invasive fungal infection, to be prescribed under an established protocol  Possible invasive fungal infection  A multidisciplinary team (including an infectious disease physician or a clinical microbiologist) considers the treatment to be	PRES	CRIE	BER			PATIENT:
INITIATION Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a clinical microbiologist, haematologist, infectious disease specialist, oncologist, respiratory specialist or transplant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Proven or probable invasive fungal infection, to be prescribed under an established protocol  Possible invasive fungal infection and	Name	:				Name:
Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a clinical microbiologist, haematologist, infectious disease specialist, oncologist, respiratory specialist or transplant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Proven or probable invasive fungal infection, to be prescribed under an established protocol  Possible invasive fungal infection  and	Ward					NHI:
Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a clinical microbiologist, haematologist, infectious disease specialist, oncologist, respiratory specialist or transplant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Proven or probable invasive fungal infection, to be prescribed under an established protocol  Possible invasive fungal infection  and	Casp	ofu	ngin			
appropriate	Prer		Prescritranspl	bed ant s	by, or recommended by a clinical microbiologist, haemato pecialist, or in accordance with a protocol or guideline the en or probable invasive fungal infection, to be prescribed a Possible invasive fungal infection  A multidisciplinary team (including an infectious disease	at has been endorsed by the Health NZ Hospital.

I confirm that the above details are correct:

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

PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Clofazimine				
INITIATION				
Prerequisites (tick box where appropriate)				
O Prescribed by, or recommended by a clinical microbiologist, dermatologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				

#### Form RS1078 January 2025

### HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 176

PRESCR	IBER	PATIENT:			
Name:		Name:			
Ward:		NHI:			
Dapsone					
INITIATION Prerequisites (tick box where appropriate)					
0	O Prescribed by, or recommended by a clinical microbiologist, dermatologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				

#### Form RS1079 January 2025

### HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 177

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Cycloserine	
INITIATION Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

Page 178

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Isoniazid with rifampicin	
INITIATION Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, dermatologist, paediatrician, public health physician or internal medicine physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pyrazinamide	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Rifampicin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, dermate or in accordance with a protocol or guideline that has been endorsed	ologist, internal medicine physician, paediatrician or public health physician, d by the Health NZ Hospital.

Page 181

PRES	CRIBER		PATIENT:
Name	):		Name:
Ward	:		NHI:
Beda	aquiline		
Re-a	ssessment re	Iti-drug resistant tuberculosis equired after 6 months k boxes where appropriate)	
The person has multi-drug resistant tuberculosis (MDR-TB) and Ministry of Health's Tuberculosis Clinical Network has reviewed the individual case and recommends bedaquiline as treatment regimen			
			d the individual case and recommends bedaquiline as part of the

ı	confirm that the above details are correct:		
S	igned:	Date:	

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Isoniazid			
INITIATION			
Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by a clinical microbiologist, dermatologist, paediatrician, public health physician or internal medicine physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Rifabutin			
INITIATION			
Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by a clinical microbiologist, gastroenterologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Ethambutol hydrochloride			
INITIATION			
Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Para-aminosalicylic Acid			
INITIATION			
Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			

#### Form RS1084 January 2025

#### HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 186

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Protionamide		
INITIATION		
Prerequisites (tick box where appropriate)		
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		

#### Form RS1088 January 2025

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Albendazole		
INITIATION		
Prerequisites (tick box where appropriate)		
O Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that habeen endorsed by the Health NZ Hospital.		

#### Form RS1283 January 2025

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Ivermectin			
INITIATION			
Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by a clinical microbiologist, dermatologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Artemether with lumefantrine			
INITIATION			
Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that habeen endorsed by the Health NZ Hospital.			

#### Form RS1091 January 2025

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 190

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Artesunate			
INITIATION			
Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that habeen endorsed by the Health NZ Hospital.			

Page 191

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:		
Atovaquone with proguanil hydrochloride			
INITIATION			
Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Chloroquine phosphate	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, dermatologist, infectious disease specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Mefloquine hydrochloride	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, dermate a protocol or guideline that has been endorsed by the Health NZ Ho	ologist, infectious disease specialist or rheumatologist, or in accordance with spital.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pentamidine isethionate	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Primaquine phosphate	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

#### Form RS1098 January 2025

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pyrimethamine	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or maternal-foetal medicine specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Quinine dihydrochloride	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Sodium stibogluconate	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infection been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

#### Form RS1101 January 2025

#### HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:
Spiramycin	
INITIATION Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a maternal-foetal medicine spe by the Health NZ Hospital.	cialist, or in accordance with a protocol or guideline that has been endorsed

Page 200

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Nitazoxanide	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infect been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

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:
lon-Nucleoside	e Reverse Transcriptase Inhibitors	
INITIATION – Confi Prerequisites (tick	irmed HIV box where appropriate)	
O Patient ha	as confirmed HIV infection	
	ention of maternal transmission boxes where appropriate)	
or	vention of maternal foetal transmission atment of the newborn for up to eight weeks	
Prerequisites (tick	exposure prophylaxis following exposure to HIV boxes where appropriate)  atment course to be initiated within 72 hours post exposure	e
or O	Patient has had condomless anal intercourse or reception unknown or detectable viral load greater than 200 copies and the patient has shared intravenous injecting equipment with	
or O		nician considers that the risk assessment indicates prophylaxis is
	Patient has had condomless anal intercourse with a per is unknown	son from a high HIV prevalence country or risk group whose HIV status
Note: Refer to local	health pathways or the Australasian Society for HIV, Viral	Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.a
Prerequisites (tick	utaneous exposure box where appropriate) as percutaneous exposure to blood known to be HIV positive	ve

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:
Nucleoside Reverse Transcriptase Inhibitors	
INITIATION – Confirmed HIV Prerequisites (tick box where appropriate)	
O Patient has confirmed HIV infection	
INITIATION – Prevention of maternal transmission Prerequisites (tick boxes where appropriate)	
O Prevention of maternal foetal transmission or O Treatment of the newborn for up to eight weeks	
INITIATION – Post-exposure prophylaxis following exposure to HIV  Prerequisites (tick boxes where appropriate)  Treatment course to be initiated within 72 hours post exposure and	е
or O Patient has shared intravenous injecting equipment with	
or O Patient has had condomless anal intercourse with a per is unknown	son from a high HIV prevalence country or risk group whose HIV status
Note: Refer to local health pathways or the Australasian Society for HIV, Viral	Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.ashn
INITIATION – Percutaneous exposure Prerequisites (tick box where appropriate)	
O Patient has percutaneous exposure to blood known to be HIV positi	ve

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:
Protease Inhibitors	
INITIATION – Confirmed HIV Prerequisites (tick box where appropriate)  O Patient has confirmed HIV infection	
INITIATION – Prevention of maternal transmission Prerequisites (tick boxes where appropriate)  Or Prevention of maternal foetal transmission or Treatment of the newborn for up to eight weeks	
INITIATION – Post-exposure prophylaxis following exposure to HIV  Prerequisites (tick boxes where appropriate)  Treatment course to be initiated within 72 hours post exposure and	
or  Patient has shared intravenous injecting equipment with  Patient has had non-consensual intercourse and the clir required  Or	
Note: Refer to local health pathways or the Australasian Society for HIV, Viral	Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.ashm
INITIATION – Percutaneous exposure Prerequisites (tick box where appropriate)  O Patient has percutaneous exposure to blood known to be HIV positive.	ve

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:
Strand Transfer Inhibitors	
INITIATION – Confirmed HIV Prerequisites (tick box where appropriate)  O Patient has confirmed HIV infection	
INITIATION – Prevention of maternal transmission Prerequisites (tick boxes where appropriate)	
O Prevention of maternal foetal transmission or O Treatment of the newborn for up to eight weeks	
INITIATION – Post-exposure prophylaxis following exposure to HIV  Prerequisites (tick boxes where appropriate)  Treatment course to be initiated within 72 hours post exposure and	e
Patient has had condomless anal intercourse or receptive unknown or detectable viral load greater than 200 copies or Patient has shared intravenous injecting equipment with or Patient has had non-consensual intercourse and the clir required or	
Note: Refer to local health pathways or the Australasian Society for HIV, Viral	Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.ashn
INITIATION – Percutaneous exposure Prerequisites (tick box where appropriate)	
O Patient has percutaneous exposure to blood known to be HIV position	ve

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:

#### Ledipasvir with sofosbuvir

Note: Only for use in patients with approval by the Hepatitis C Treatment Panel (HepCTP). Applications will be considered by HepCTP at its regular meetings and approved subject to eligibility according to the Access Criteria (set out in Section B of the Pharmaceutical Schedule).

#### Form RS1108 January 2025

#### HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:		
Cidofovir			
INITIATION			
Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by a clinical microbiologist, infection a protocol or guideline that has been endorsed by the Health NZ Ho	us disease specialist, otolaryngologist or oral surgeon, or in accordance with spital.		

#### Form RS1109 January 2025

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Foscarnet sodium	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

#### Form RS1110 January 2025

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:		
Ganciclovir			
INITIATION			
Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has		

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.

RESCRIBER PATIENT:			
Name:	ne:Name:		
Ward:	ard:NHI:		
/alganciclovir			
INITIATION – Transplant cytomegal Re-assessment required after 3 mont Prerequisites (tick box where approp  Patient has undergone a so	hs		
CONTINUATION – Transplant cyton Re-assessment required after 3 mont Prerequisites (tick boxes where appr	hs		
and CMV prophylaxi	ergone a solid organ transplant and received anti-thymocyte globulin and requires valganciclovir therapy for is eive a maximum of 90 days of valganciclovir prophylaxis following anti-thymocyte globulin		
O Patient has received pulse methylprednisolone for acute rejection and requires further valganciclovir therapy for CMV prophylaxis  and O Patient is to receive a maximum of 90 days of valganciclovir prophylaxis following pulse methylprednisolone			
INITIATION – Lung transplant cytor Re-assessment required after 12 mor Prerequisites (tick boxes where appr  Prescribed by, or recommen Hospital.	nths		
O Patient has undergone	e a lung transplant		
or	cytomegalovirus positive and the patient is cytomegalovirus negative cytomegalovirus positive c of CMV disease		
INITIATION – Cytomegalovirus in in Prerequisites (tick boxes where appr			

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:		
Emtricitabine with tenofovir disoproxil		
INITIATION – Confirmed HIV Prerequisites (tick box where appropriate)		
O Patient has confirmed HIV infection		
INITIATION – Prevention of maternal transmission Prerequisites (tick boxes where appropriate)		
O Prevention of maternal foetal transmission  O Treatment of the newborn for up to eight weeks		
INITIATION – Post-exposure prophylaxis following non-occupational exp Prerequisites (tick boxes where appropriate)	osure to HIV	
Treatment course to be initiated within 72 hours post exposure and		
O Patient has had unprotected receptive anal intercourse v	vith a known HIV positive person	
O Patient has shared intravenous injecting equipment with	a known HIV positive person	
Patient has had non-consensual intercourse and the clir required	ician considers that the risk assessment indicates prophylaxis is	
INITIATION – Percutaneous exposure Prerequisites (tick box where appropriate)		
O Patient has percutaneous exposure to blood known to be HIV positiv	e e	
INITIATION – Pre-exposure prophylaxis Re-assessment required after 24 months		
Prerequisites (tick boxes where appropriate)		
and	oms of acute HIV infection and has been assessed for HIV seroconversion	
The Practitioner considers the patient is at elevated risk of HIV		
Note: Refer to local health pathways or the Australasian Society for HIV, Viral	Hepatitis and Sexual Health Medicine clinical guidelines (https://ashm.org.au/HIV/P	
CONTINUATION – Pre-exposure prophylaxis Re-assessment required after 24 months Prerequisites (tick boxes where appropriate)		
O Patient has tested HIV negative, does not have signs or sympt and	oms of acute HIV infection and has been assessed for HIV seroconversion	
The Practitioner considers the patient is at elevated risk of HIV	exposure and use of PrEP is clinically appropriate	
Note: Refer to local health pathways or the Australasian Society for HIV, Viral	Hepatitis and Sexual Health Medicine clinical guidelines (https://ashm.org.au/HIV/P	

I confirm that the above details are correct:

Signed: Date:

PRES	SCR	IBER		PATIENT:
Name	e:			Name:
Ward:			NHI:	
Osel	ltar	nivir		
INITI Prer			(tick boxes where appropriate)	
Only for hospitalised patient with known or suspected influenza		a		
	or	о О	For prophylaxis of influenza in hospitalised patients as part of	a Health NZ Hospital approved infections control plan

PRES	SCR	RIBER	PATIENT:
Name	e:		Name:
Ward:			NHI:
Zana	ami	ivir - Powder for inhalation 5 mg	
INITI Prer		ION uisites (tick boxes where appropriate)	
Only for hospitalised patient with known or suspected influenza		ra	
	or	O For prophylaxis of influenza in hospitalised patients as part of	a Health NZ Hospital approved infections control plan

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
COVID-19 treatments	
INITIATION	
Prerequisites (tick box where appropriate)	
Only if patient meets access criteria (as per https://pharmac.govt.nz/covid-oral-antivirals). Note the supply of treatment is via Pharmac's approved distribution process. Refer to the Pharmac website for more information about this and stock availability	

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
COVID-19 treatments			
INITIATION			
Prerequisites (tick box where appropriate)			
Only if patient meets access criteria (as per https://pharmac.govt.nz/covid-oral-antivirals). Note the supply of treatment is via Pharmac's approved distribution process. Refer to the Pharmac website for more information about this and stock availability			

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Remdesivir	
INITIATION – Treatment of mild to moderate COVID-19 Prerequisites (tick box where appropriate)  Only if patient meets access criteria (as per https://pharmac.govt.nz/approved distribution process. Refer to the Pharmac website for moderate COVID-19	covid-oral-antivirals). Note the supply of treatment is via Pharmac's re information about this and stock availability
INITIATION – COVID-19 in hospitalised patients Re-assessment required after 5 doses Prerequisites (tick boxes where appropriate)  Patient is hospitalised with confirmed (or probable) symptomate and Patient is considered to be at high risk of progression to severe and Patient's symptoms started within the last 7 days and Patient does not require, or is not expected to require, mechanism	e disease
Not to be used in conjunction with other funded COVID-19 anti	viral treatments

I confirm that the above details are correct	ct:
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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:
Interferon gamma	
INITIATION Prerequisites (tick box where appropriate)	
O Patient has chronic granulomatous disease and requires interferon	gamma

I confirm that the above details are correct:

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

#### 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 - INITIATION	liver transplant
Chronic hepatitis C - genotype 2 or 3 infection without co-infection with HIV - INITIATION	
Myeloproliferative disorder or cutaneous T cell lymphoma - INITIATION	219
Ocular surface squamous neoplasia - INITIATIÓN	220
Post-allogenic bone marrow transplant - INITIATION	220

I confirm that the above details are correct:

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

lame:	Name:
/ard:	NHI:
egylated in	terferon alfa-2a
	thronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV or genotype 2 or 3 post liver transplant
	required after 48 weeks tick boxes where appropriate)
	Patient has chronic hepatitis C, genotype 1, 4, 5 or 6 infection
or O	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
eatment since onsider reduci	stopping treatment if there is absence of a virological response (defined as at least a 2-log reduction in viral load) following 12 weeks of this is predictive of treatment failure.  ng treatment to 24 weeks if serum HCV RNA level at Week 4 is undetectable by sensitive PCR assay (less than 50IU/ml) AND Baseline A is less than 400,000IU/ml.
e-assessment	N – Chronic hepatitis C - genotype 1 infection required after 48 weeks
rerequisites (	tick boxes where appropriate)
	ribed by, or recommended by a gastroenterologist, infectious disease specialist or general physician, or in accordance with a protocol or ine that has been endorsed by the Health NZ Hospital.
and 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
NITIATION – C	hronic Hepatitis C - genotype 1 infection treatment more than 4 years prior
e-assessment	required after 48 weeks tick boxes where appropriate)
	ribed by, or recommended by a gastroenterologist, infectious disease specialist or general physician, or in accordance with a protocol or ine that has been endorsed by the Health NZ Hospital.
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
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: .....

PRESCRIBER		TIENT:
Name:	Nar	ne:
Ward:	l:	
Pegylate	ed interferon alfa-2a - continued	
Re-assess	ON – Chronic hepatitis C - genotype 2 or 3 infection without co-infect sment required after 6 months sites (tick box where appropriate)	ion with HIV
	Patient has chronic hepatitis C, genotype 2 or 3 infection	
Re-assess Prerequisi	DN – Hepatitis B sment required after 48 weeks sites (tick boxes where appropriate)  Prescribed by, or recommended by a gastroenterologist, infectious disease guideline that has been endorsed by the Health NZ Hospital.	se specialist or general physician, or in accordance with a protocol or
and	O Patient has confirmed Hepatitis B infection (HBsAg positive for mor	re than 6 months)
and ( and	Patient is Hepatitis B treatment-naive	
and (	O HBV DNA < 10 log10 IU/ml	
and	O HBeAg positive	
	moderate fibrosis)	significant fibrosis (greater than or equal to Metavir Stage F2 or
and ( and	O Compensated liver disease	
and	O No continuing alcohol abuse or intravenous drug use	
and	Not co-infected with HCV, HIV or HDV	
and	O Neither ALT nor AST > 10 times upper limit of normal	
(	O No history of hypersensitivity or contraindications to pegylated inter	feron
Re-assess	ON – myeloproliferative disorder or cutaneous T cell lymphoma isment required after 12 months sites (tick boxes where appropriate)	
or (	O Patient has a cutaneous T cell lymphoma*	
	Patient has a myeloproliferative disorder*	
	Patient is intolerant of hydroxyurea and  Treatment with anagrelide and busulfan is not clinically appro	priate
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 lymphone Re-assessment required after 12 months  Prerequisites (tick boxes where appropriate)  No evidence of disease progression and  The treatment remains appropriate and patient is benefitting fround			
O Patient has a cutaneous T cell lymphoma*			
Patient has a myeloproliferative disorder*  O Remains intolerant of hydroxyurea and treat or O Patient is pregnant, planning pregnancy or la  Note: Indications marked with * are unapproved indications	ment with anagrelide and busulfan remains clinically inappropriate actating		
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 accordate Hospital.  and O Patient has ocular surface squamous neoplasia*	ance with a protocol or guideline that has been endorsed by the Health NZ		
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.			
The treatment remains appropriate and patient is benefitting from tre Note: Indications marked with * are unapproved indications	atment		
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: .....

#### Musculoskeletal System



PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Edrophonium chloride	
INITIATION	
Prerequisites (tick box where appropriate)	
O For the diagnosis of myasthenia gravis	

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.

CRIBE	:R	PATIENT:
:		
		NHI:
suma	ab	
ATION	aa (tio	ek boxes where appropriate)
	es (iic	in boxes where appropriate)
and	) Th	ne patient has severe, established osteoporosis
	or (	The patient is female and postmenopausal
		The patient is male or non-binary
and		
	or or or or	History of one significant osteoporotic fracture demonstrated radiologically and documented bone mineral density (BMD) greater than or equal to 2.5 standard deviations below the mean normal value in young adults (i.e. T-Score less than or equal to -2.5) (see Note)  History of one significant osteoporotic fracture demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of major logistical, technical or pathophysiological reasons  History of two significant osteoporotic fractures demonstrated radiologically  Documented T-Score less than or equal to -3.0 (see Note)  A 10-year risk of hip fracture greater than or equal to 3%, calculated using a published risk assessment algorithm (e.g. FRAX or Garvan) which incorporates BMD measurements (see Note)  Patient has had a Special Authority approval for alendronate (Underlying cause - Osteoporosis) prior to 1 February 2019 or has had a Special Authority approval for raloxifene
and and	) Th	pledronic acid is contraindicated because the patient's creatinine clearance is less than 35 mL/min  ne patient has experienced at least one symptomatic new fracture after at least 12 months' continuous therapy with a funded ntiresorptive agent at adequate doses (see Notes)  ne patient must not receive concomitant treatment with any other funded antiresorptive agent for this condition or teriparatide

#### Note:

- a) BMD (including BMD used to derive T-Score) must be measured using dual-energy x-ray absorptiometry (DXA).
   Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable.
- b) Evidence suggests that patients aged 75 years and over who have a history of significant osteoporotic fracture demonstrated radiologically are very likely to have a T-Score less than or equal to -2.5 and, therefore, do not require BMD measurement for treatment with denosumab.
- c) Osteoporotic fractures are the incident events for severe (established) osteoporosis and can be defined using the WHO definitions of osteoporosis and fragility fracture. The WHO defines severe (established) osteoporosis as a T-score below -2.5 with one or more associated fragility fractures. Fragility fractures are fractures that occur as a result of mechanical forces that would not ordinarily cause fracture (minimal trauma). The WHO has quantified this as forces equivalent to a fall from a standing height or less.
- d) A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.
- e) Antiresorptive agents and their adequate doses for the purposes of this Special Authority are defined as: risedronate sodium tab 35 mg once weekly; alendronate sodium tab 70 mg or tab 70 mg with cholecalciferol 5,600 iu once weekly; raloxifene hydrochloride tab 60 mg once daily. If an intolerance of a severity necessitating permanent treatment withdrawal develops during the use of one antiresorptive agent, an alternate antiresorptive agent must be trialled so that the patient achieves the minimum requirement of 12 months' continuous therapy.

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.

PRESCF	RIBER	PATIENT:
Name: .		Name:
Ward:		NHI:
Raloxif	ene	
INITIAT Prerequ		s (tick boxes where appropriate)
OI	· O	History of one significant osteoporotic fracture demonstrated radiologically and documented bone mineral density (BMD) greater than or equal to 2.5 standard deviations below the mean normal value in young adults (i.e. T-Score less than or equal to -2.5) (see Notes)  History of one significant osteoporotic fracture demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of major logistical, technical or pathophysiological reasons. It is unlikely that this provision would apply
OI OI	0	to many patients under 75 years of age  History of two significant osteoporotic fractures demonstrated radiologically  Documented T-Score greater than or equal to -3.0 (see Notes)
OI	0	A 10-year risk of hip fracture greater than or equal to 3%, calculated using a published risk assessment algorithm (e.g. FRAX or Garvan) which incorporates BMD measurements (see Notes)  Patient has had a Special Authority approval for zoledronic acid (Underlying cause - Osteoporosis) or has had a Special Authority approval for alendronate (Underlying cause - Osteoporosis) prior to 1 February 2019

#### Note:

- a) BMD (including BMD used to derive T-Score) must be measured using dual-energy x-ray absorptiometry (DXA).
   Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable.
- b) Evidence suggests that patients aged 75 years and over who have a history of significant osteoporotic fracture demonstrated radiologically are very likely to have a T-Score less than or equal to -2.5 and, therefore, do not require BMD measurement for raloxifene funding.
- c) Osteoporotic fractures are the incident events for severe (established) osteoporosis, and can be defined using the WHO definitions of osteoporosis and fragility fracture. The WHO defines severe (established) osteoporosis as a T-score below -2.5 with one or more associated fragility fractures. Fragility fractures are fractures that occur as a result of mechanical forces that would not ordinarily cause fracture (minimal trauma). The WHO has quantified this as forces equivalent to a fall from a standing height or less.
- d) A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

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	l	PATIENT:
Name:		Name:
Ward:		NHI:
Teriparatid	e	
	ent required after 18 months s (tick boxes where appropriate)	
and	The patient has severe, established osteoporosis  The patient has a documented T-score less than or equal to -5	2.0 (one Neton)
and  The patient has a documented 1-score less than or equal to -5.0 (see Notes)  The patient has had two or more fractures due to minimal trauma		
and	The patient has experienced at least one symptomatic new fra antiresorptive agent at adequate doses (see Notes)	acture after at least 12 months' continuous therapy with a funded

#### Note:

- a) The bone mineral density (BMD) measurement used to derive the T-score must be made using dual-energy x-ray absorptiometry (DXA). Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable
- b) Antiresorptive agents and their adequate doses for the purposes of this restriction are defined as: alendronate sodium tab 70 mg or tab 70 mg with colecalciferol 5,600 iu once weekly; raloxifene hydrochloride tab 60 mg once daily; zoledronic acid 5 mg per year. If an intolerance of a severity necessitating permanent treatment withdrawal develops during the use of one antiresorptive agent, an alternate antiresorptive agent must be trialled so that the patient achieves the minimum requirement of 12 months' continuous therapy.
- c) A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

I confirm that the above details are correct:	
Signed:	Date:

#### Form RS1016 January 2025

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 226

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Rasburicase			
INITIATION			
Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			

PRESCRIBER PATIENT:			PATIENT:
Name: Name:			Name:
Vard:			NHI:
ebuxos	tat		
INITIATIO	N – (	Gout	
Prerequis	sites	(tick boxes where appropriate)	
and	O	Patient has been diagnosed with gout	
		O The patient has a serum urate level greater than 0.36 m and addition of probenecid at doses of up to 2 g per day	mol/l despite treatment with allopurinol at doses of at least 600 mg/day or maximum tolerated dose
	or	O The patient has experienced intolerable side effects from allopurinol such that treatment discontinuation is required and serum urate remains greater than 0.36 mmol/l despite use of probenecid at doses of up to 2 g per day or maximum tolerated dose	
	or	O The patient has renal impairment such that probenecid is contraindicated or likely to be ineffective and serum urate remains greater than 0.36 mmol/l despite optimal treatment with allopurinol (see Note)	
	0.	O The patient has previously had an initial Special Authori	ty approval for benzbromarone for treatment of gout.
Prescribed by, or recommended by a haematologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  and  Patient is scheduled to receive cancer therapy carrying an intermediate or high risk of tumour lysis syndrome and  Patient has a documented history of allopurinol intolerance			
Re-assess	smen	ON – Tumour lysis syndrome t required after 6 weeks (tick box where appropriate)	
H	O Prescribed by, or recommended by a haematologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by Health NZ Hospital.		
and	The t	reatment remains appropriate and patient is benefitting from tre	eatment

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER				PATIENT:	
Name	:			Name:	
Ward:				NHI:	
Suga	ımn	nade	ex		
INITI. Prere			(tick boxes where appropriate)		
	O Patient requires reversal of profound neuromuscular blockade following rapid sequence induction that has been undertaken using rocuronium (i.e. suxamethonium is contraindicated or undesirable)				
Severe neuromuscular degenerative disease where the us		Severe neuromuscular degenerative disease where the use of	neuromuscular blockade is required		
	or	0	Patient has an unexpectedly difficult airway that cannot be intublockade	bated and requires a rapid reversal of anaesthesia and neuromuscular	
or or		0	The duration of the patient's surgery is unexpectedly short		
		0	Neostigmine or a neostigmine/anticholinergic combination is c morbid obesity or COPD)	ontraindicated (for example the patient has ischaemic heart disease,	
	$\circ$	Patient has a partial residual block after conventional reversal			

#### Form RS1592 January 2025

#### HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 229

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:		
Etoricoxib			
INITIATION Prerequisites (tick box where appropriate)			
For in-vivo investigation of allergy only			

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Capsaicin			
INITIATION Prerequisites (tick box where appropriate)			
O Patient has osteoarthritis that is not responsive to paracetamol and oral non-steroidal anti-inflammatories are contraindicated			

#### **Nervous System**



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:		
Riluzole			
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a neurologist or respiratory specified by the Health NZ Hospital.	cialist, or in accordance with a protocol or guideline that has been endorsed		
The patient has amyotrophic lateral sclerosis with disease duration of 5 years or less  The patient has at least 60 percent of predicted forced vital capacity within 2 months prior to the initial application and  The patient has not undergone a tracheostomy and  The patient has not experienced respiratory failure  The patient is ambulatory  The patient is able to use upper limbs  The patient is able to swallow			
CONTINUATION Re-assessment required after 18 months Prerequisites (tick boxes where appropriate)			
The patient has not undergone a tracheostomy and The patient has not experienced respiratory failure and			
The patient is ambulatory  The patient is able to use upper limbs  or  The patient is able to swallow			

I confirm that the above details are correct:

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#### Form RS1763 January 2025

#### HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 233

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:			
Sucrose				
INITIATION Prerequisites (tick box where appropriate)				
O For use in neonatal patients only				

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Methoxyflurane			
INITIATION Prerequisites (tick boxes where appropriate)			
Patient is undergoing a painful procedure with an expected du	O Patient is undergoing a painful procedure with an expected duration of less than one hour		
Only to be used under supervision by a medical practitioner of	or nurse who is trained in the use of methoxyflurane		

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Paracetamol		
INITIATION		
Prerequisites (tick box where appropriate)		
O Intravenous paracetamol is only to be used where other routes are unavailable or impractical, or where there is reduced absorption. The need for IV paracetamol must be re-assessed every 24 hours		

#### Form RS1145 January 2025

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 236

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:		
Capsaicin			
INITIATION Prerequisites (tick box where appropriate)			
O For post-herpetic neuralgia or diabetic peripheral neuropathy			

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		PAT	PATIENT:	
Name	:		Nan Nan	ne:
Ward:			NHI	:
Vigal	batri	n		
	ssess	ment	nt required after 15 months (tick boxes where appropriate)	
		or	O Patient has infantile spasms	
			O Patient has epilepsy and	
or Seizures are controlled adequately				nal treatment with other antiepilepsy agents  It has experienced unacceptable side effects from optimal
		or	O Patient has tuberous sclerosis complex	
	and		O Patient is, or will be, receiving regular automated visual field thereafter)	esting (ideally before starting therapy and on a 6-monthly basis
		or	O It is impractical or impossible (due to comorbid conditions) to	monitor the patient's visual fields
CON <sup>o</sup>			ON (tick boxes where appropriate)	
O The patient has demonstrated a significant and sustained improvement in seizure rate or severity and or quality and		nent in seizure rate or severity and or quality of life		
		or	O Patient is receiving regular automated visual field testing (ide with vigabatrin	ally every 6 months) on an ongoing basis for duration of treatment
		Oi	O It is impractical or impossible (due to comorbid conditions) to	monitor the patient's visual fields

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

Page 238

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Lacosamide	
INITIATION Re-assessment required after 15 months Prerequisites (tick boxes where appropriate)	
Patient has focal epilepsy  and  Seizures are not adequately controlled by or	patient has experienced unacceptable side effects from, optimal treatment with all of the
following: sodium valproate, topiramate, leve	patient has experienced unacceptable side enects from, optimal treatment with all of the stiracetam, and any two of carbamazepine, lamotrigine, and phenytoin sodium (see Note)
Note: Those of childbearing potential are not required to trial required to trial sodium valproate.	I phenytoin sodium, sodium valproate, or topiramate. Those who can father children are not

I confirm that the above details are correct:

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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.

PRES	SCRIBER PATIENT:
Name	: Name:
Ward:	NHI:
Stiri	pentol
Re-a	ATION ssessment required after 6 months equisites (tick boxes where appropriate)  Prescribed by, or recommended by a paediatric neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	Patient has confirmed diagnosis of Dravet syndrome  Seizures have been inadequately controlled by appropriate courses of sodium valproate, clobazam and at least two of the following: topiramate, levetiracetam, ketogenic diet
	: Those of childbearing potential are not required to trial sodium valproate or topiramate. Those who can father children are not required to trial um valproate.
	TINUATION equisites (tick box where appropriate)  Prescribed by, or recommended by a paediatric neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health
and (	NZ Hospital.  Patient continues to benefit from treatment as measured by reduced seizure frequency from baseline

I confirm that the above details are correct:

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PRESC	RIBEF	1	PATIENT:
Name:			Name:
Ward:			NHI:
Hyoso	ine h	ydrobromide - Patch 1.5 mg	
		patient cannot tolerate or does not adequately respond to oral Control of clozapine-induced hypersalivation where trials of at	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Aprepitant	
INITIATION Prerequisites (tick box where appropriate)	
O Patient is undergoing highly emetogenic chemotherapy and/or anthracycline-based chemotherapy for the treatment of malignancy	

PRESCRIBER		PATIENT:
Name:		Name:
Ward:		NHI:
Paliperidon	e	
	nt required after 12 months (tick boxes where appropriate)	
or an	The patient has schizophrenia or other psychotic disorded.  The patient has been unable to adhere to treatment using the contraction of the patient has been unable to adhere to treatment using the contraction of the patient has been unable to adhere to treatment using the contraction of the patient has been unable to adhere to treatment using the contraction of the patient has been unable to adhere the patien	
Prerequisites  The i	nt required after 12 months (tick box where appropriate)	th fewer days of intensive intervention than was the case during a

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Oigilica.	 Duic.	

Use this checklist to determine if a patient meets the restrictions for funding in the Schedule. For community funding, see the Special Authority Criteria.	ne <b>hospital setting</b> . For more details, refer to Section H of the Pharmaceutical
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Paliperidone palmitate	
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)  Or The patient has schizophrenia and The patient has had an initial Special Authority approval for patient has had an initial Special Authority approval for patient has had an initial Special Authority approval for patient has had an initial Special Authority approval for patient has had an initial Special Authority approval for patient has had an initial Special Authority approval for patient has had an initial Special Authority approval for patient has had an initial Special Authority approval for patient has had an initial Special Authority approval for patient has had an initial Special Authority approval for patient has had an initial Special Authority approval for patient has had an initial Special Authority approval for patient has had an initial Special Authority approval for patient has had an initial Special Authority approval for patient has had an initial Special Authority approval for patient has had an initial Special Authority approval for patient has had an initial Special Authority approval for patient has had an initial Special Authority approval for patient has had an initial Special Authority approval for patient had be approximated	aliperidone once-monthly depot injection
CONTINUATION  Re-assessment required after 12 months  Prerequisites (tick box where appropriate)  The initiation of paliperidone depot injection has been associated with corresponding period of time prior to the initiation of an atypical antiperior antiperior to the initiation of an atypical antiperior and antiperior antiperior and attached antiperior and attached antiperior and attached antiperior and attached antiperior antiperior and attached antiperior and attached antiperior and attached antiperior antiperior antiperior antiperior antiperior antiperior and attached antiperior antipe	

I confirm that the above details are correct:

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#### Form RS2018 January 2025

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 244

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:
Olanzapine	
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate)	
The initiation of olanzapine depot injection has been associated with corresponding period of time prior to the initiation of an atypical antiple.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Risperidone	
or depot injection	aliperidone depot injection or olanzapine depot injection or aripiprazole
The patient has schizophrenia or other psychotic disorder and The patient has not been able to adhere to treatment us and The patient has been admitted to hospital or treated in reason and and and and the patient has been admitted to hospital or treated in reason and the last 12 months	
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate)  The initiation of risperidone depot injection has been associated with corresponding period of time prior to the initiation of an atypical antip	

I confirm that the above details are correc
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Oigilica.	 Duic.	

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.

PRESCRIE	BER	PATIENT:
Name:		
Ward:		NHI:
Aripipra	zole	
INITIATIO Prerequis		(tick boxes where appropriate)
	or	O The patient has had an initial Special Authority approval for risperidone depot injection or paliperidone depot injection or olanzapine depot injection
		The patient has schizophrenia or other psychotic disorder  and  The patient has received treatment with oral atypical antipsychotic agents but has been unable to adhere and  The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in last 12 months
or		Patient has been unable to access olanzapine depot injection due to supply issues with olanzapine depot injection, or otherwise would have been initiated on olanzapine depot injection but has been unable to due to supply issues with olanzapine depot injection. (see Note below for the olanzapine Special Authority criteria for new olanzapine depot injection patients prior to 1 April 2024)
Note: The	e Olan	nzapine depot injection Special Authority criteria that apply to criterion 2 in this Aripiprazole Special Authority application are as follows:
The pa	atient l	has had an initial Special Authority approval for paliperidone depot injection or risperidone depot injection; or
All of ti	the foll	lowing:
• The	e patie	ent has schizophrenia; and
• The	e patie	ent has tried but has not been able to adhere with treatment using oral atypical antipsychotic agents; and
	•	ent has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in the last

I confirm that the above details are correct:

12 months.

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Zigneg.	i jate:	
Oigilica.	 Duic.	

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.

PRESCR	IBER	PATIENT:
Name:		Name:
Ward:		NHI:
Diazepa	am	
INITIATI Prerequ	ON isites (tick box where appropriate)	
0	Prescribed by, or recommended by a relevant specialist, or in accord Hospital.	dance with a protocol or guideline that has been endorsed by the Health NZ
and	Only for use in children where diazepam tablets are not appropriate	

SCRIBER	PATIENT:
e:	Name:
:	NHI:
iple Scle	rosis
teriflunomi sssessment	ultiple Sclerosis - dimethyl fumarate, fingolimod, glatiramer acetate, interferon beta-1-alpha, interferon beta-1-beta, natalizur de required after 12 months ick boxes where appropriate)
O Prescr NZ Ho	ibed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Hespital.
	O Diagnosis of multiple sclerosis (MS) meets the McDonald 2017 diagnostic criteria for MS and has been confirmed by a neurologist
and	O Patient has an EDSS score between 0 – 6.0
and	Patient has had at least one significant attack of MS in the previous 12 months or two significant attacks in the past 24 months
	Each significant attack must be confirmed by the applying neurologist or general physician (the patient may not necessarily have been seen by them during the attack, but the neurologist/physician must be satisfied that the clinical features were characteristic)  and
	Each significant attack is associated with characteristic new symptom(s)/sign(s) or substantially worsening of previously experienced symptoms(s)/sign(s)
	Each significant attack has lasted at least one week and has started at least one month after the onset of a previous attack (where relevant)
	Each significant attack can be distinguished from the effects of general fatigue; and is not associated with a fever (T> 37.5°C)
	Each significant attack is severe enough to change either the EDSS or at least one of the Kurtze Functional System scores by at least 1 point     Each significant attack is a recurrent paroxysmal symptom of multiple sclerosis (tonic seizures/spasms,
	trigeminal neuralgia, Lhermitte's symptom)
and	Evidence of new inflammatory activity on an MRI scan within the past 24 months
	A sign of that new inflammatory activity on MRI scanning (in criterion 5 immediately above) is a gadolinium enhancing lesion
	O A sign of that new inflammatory activity is a lesion showing diffusion restriction or
	A sign of that new inflammatory is a T2 lesion with associated local swelling  Or  A sign of that new inflammatory activity is a prominent T2 lesion that clearly is responsible for the clinical features of a
	recent attack that occurred within the last 2 years  Or  A sign of that new inflammatory activity is a profilinent 12 lesion that clearly is responsible for the clinical features of a recent attack that occurred within the last 2 years  Or  A sign of that new inflammatory activity is new T2 lesions compared with a previous MRI scan
or	A sign of that new initialitinatory activity is new 12 lesions compared with a previous wird scan
	Patient has an active approval for ocrelizumab and does not have primary progressive MS
: Treatmen	on two or more funded multiple sclerosis treatments simultaneously is not permitted.

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Multiple Sclerosis - continued			
CONTINUATION – Multiple Sclerosis - dimethyl fumarate, fingolimod, glatiramer acetate, interferon beta-1-alpha, interferon beta-1-beta, natalizumab and teriflunomide			
Prerequisites (tick box where appropriate)			
NZ Hospital.	ecordance with a protocol or guideline that has been endorsed by the Health		
Patient has had an EDSS score of 0 to 6.0 (inclusive) with or without the use unilateral or bilateral aids at any time in the last six months (ie the patient has walked 100 metres or more with or without aids in the last six months)  Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.			

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.

I confirm that the above details are correct:

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

I confirm that the above details are correct:

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

Schedule. For community funding, see the Special Authority Criteria.	
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Multiple Sclerosis - continued	
CONTINUATION – Multiple Sclerosis - ocrelizumab Prerequisites (tick box where appropriate)	
NZ Hospital.	ccordance with a protocol or guideline that has been endorsed by the Health ut the use unilateral or bilateral aids at any time in the last six months (ie ne last six months) ineously is not permitted.
INITIATION – Primary Progressive Multiple Sclerosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
	ccordance with a protocol or guideline that has been endorsed by the Health
Diagnosis of primary progressive multiple sclerosis (PPMS) n neurologist	neets the 2017 McDonald criteria and has been confirmed by a
Patient has an EDSS 2.0 (score equal to or greater than 2 on and Patient has no history of relapsing remitting multiple sclerosis	
NZ Hospital.	ccordance with a protocol or guideline that has been endorsed by the Health time in the last six months (ie patient has walked 20 metres with bilateral

r respiratory specialist, or in accordance with a protocol or econdary to a neurodevelopmental disorder (including, but not order) propriate nan 10 mg per day
r respiratory specialist, or in accordance with a protocol or econdary to a neurodevelopmental disorder (including, but not order)
econdary to a neurodevelopmental disorder (including, but not order)
econdary to a neurodevelopmental disorder (including, but not order)
r respiratory specialist, or in accordance with a protocol or
lified-release melatonin (clinician determined) ation within the past 12 months and has had a recurrence of the man 10 mg per day
I
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I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Nusinersen	
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
Patient has genetic documentation of homozygous SMN1 ge heterozygous mutation  and Patient is 18 years of age or under	ne deletion, homozygous SMN1 point mutation, or compound
Patient has experienced the defined signs and symptom or  Patient is pre-symptomatic and Patient has three or less copies of SMN2	ns of SMA type I, II or IIIa prior to three years of age
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
There has been demonstrated maintenance of motor mileston and Patient does not require invasive permanent ventilation (at lea while being treated with nusinersen	e function since treatment initiation st 16 hours per day), in the absence of a potentially reversible cause
Nusinersen not to be administered in combination other SMA	disease modifying treatments or gene therapy

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Risdiplam	
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
Patient has genetic documentation of homozygous SMN1 ge heterozygous mutation  and Patient is 18 years of age or under and	ne deletion, homozygous SMN1 point mutation, or compound
O Patient has experienced the defined signs and symptom or O Patient is pre-symptomatic and O Patient has three or less copies of SMN2	ns of SMA type I, II or IIIa prior to three years of age
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
There has been demonstrated maintenance of motor mileston	
while being treated with risdiplam	st 16 hours per day), in the absence of a potentially reversible cause
O Risdiplam not to be administered in combination other SMA d	sease modifying treatments or gene therapy

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Signed.	Date:	
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PRES	CRIB	ER			PATIENT:
Name	:				Name:
Ward:					NHI:
Moda	afini	I			
	equis	ites Presc	(tick b	lepsy oxes where appropriate) by, or recommended by a neurologist or respiratory spec th NZ Hospital.	ialist, or in accordance with a protocol or guideline that has been endorsed
anu	and	0		patient has a diagnosis of narcolepsy and has excessive of months or more	daytime sleepiness associated with narcolepsy occurring almost daily for
		or	O O	The patient has a multiple sleep latency test with a mean onset rapid eye movement periods  The patient has at least one of: cataplexy, sleep paralys	is or hypnagogic hallucinations
	and		$\bigcap$		
		or		intolerable side effects	ate or dexamphetamine has been trialled and discontinued because of
				Methylphenidate and dexamphetamine are contraindicat	ed

PRESCRIBER		PATIENT:
Name:		Name:
Ward:		NHI:
Lisdexamfetamine di	mesilate	
INITIATION Prerequisites (tick boxes of the prescribed by, or Health NZ Hospit and	where appropriate) recommended by a paediatrician or psychiatrist, al.	or in accordance with a protocol or guideline that has been endorsed by the silate and met all remaining criteria prior to commencing treatment
and Diagrand  or or or or or or or and	Patient is taking a currently subsidised formulation effective due to significant administration and/or.  There is significant concern regarding the risk of Patient is taking a currently subsidised formulation release) which has not been effective due to significant concern regarding the risk of Patient is significant concern regarding the risk of Patient would have been prescribed a subsidient would have been prescribed a subsidient would have been unable to access due to supplied Other alternative stimulant presentations (in	on of dexamfetamine sulfate (immediate-release) which has not been

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Methylphenidate hydrochloride	
INITIATION – ADHD (immediate-release and sustained-release formulation in the prerequisites (tick box where appropriate)	ons)
Health NZ Hospital.	r in accordance with a protocol or guideline that has been endorsed by the
Patient has ADHD (Attention Deficit and Hyperactivity Disorder), dia	gnosed according to DSM-IV or ICD 10 criteria
INITIATION – Narcolepsy (immediate-release and sustained-release form Prerequisites (tick box where appropriate)	nulations)
by the Health NZ Hospital.	cialist, or in accordance with a protocol or guideline that has been endorsed
Patient suffers from narcolepsy	
INITIATION – Extended-release and modified-release formulations Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a paediatrician or psychiatrist, o Health NZ Hospital.	r in accordance with a protocol or guideline that has been endorsed by the
O Patient has ADHD (Attention Deficit and Hyperactivity Disorder and	er), diagnosed according to DSM-IV or ICD 10 criteria
has not been effective due to significant administration	phenidate hydrochloride (immediate-release or sustained-release) which and/or compliance difficulties
O There is significant concern regarding the risk of diversi	on or abuse of immediate-release methylphenidate hydrochloride

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Dexamphetamine sulphate	
INITIATION – ADHD Prerequisites (tick box where appropriate)  Prescribed by, or recommended by a paediatrician or psychiatrist, or Health NZ Hospital.  and  Patient has ADHD (Attention Deficit and Hyperactivity Disorder), dia	r in accordance with a protocol or guideline that has been endorsed by the gnosed according to DSM-IV or ICD 10 criteria
INITIATION – Narcolepsy Prerequisites (tick box where appropriate)  O Prescribed by, or recommended by a neurologist or respiratory specified by the Health NZ Hospital.  and O Patient suffers from narcolepsy	cialist, or in accordance with a protocol or guideline that has been endorsed

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Rivastigmine	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  The patient has been diagnosed with dementia and The patient has experienced intolerable nausea and/or vomiting	ng from donepezil tablets
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
The treatment remains appropriate and The patient has demonstrated a significant and sustained ben	efit from treatment

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Naltrexone hydrochloride	
INITIATION – Alcohol dependence Prerequisites (tick boxes where appropriate)  Patient is currently enrolled, or is planned to be enrolled, in a and Naltrexone is to be prescribed by, or on the recommendation of	recognised comprehensive treatment programme for alcohol dependence of, a physician working in an Alcohol and Drug Service
INITIATION – Constipation Prerequisites (tick box where appropriate)	
O For the treatment of opioid-induced constipation	

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PRES	CRI	BER		PATIENT:	
Name	:			Name:	
Ward:				NHI:	
Nico	tine	)			
INITIA Prere			(tick boxes where appropriate)		
		0	For perioperative use in patients who have a 'nil by mouth' inst	truction	
	or	0	For use within mental health inpatient units		
	O Patient would be admitted to a mental health inpatient unit, but is unable to due to COVID-19 self-isolation requirement				
	or	0	For acute use in agitated patients who are unable to leave the	hospital facilities	

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:
Varenicline	
INITIATION Prerequisites (tick boxes where appropriate)	
O Short-term therapy as an aid to achieving abstinence in a pati	ient who has indicated that they are ready to cease smoking
The patient is part of, or is about to enrol in, a comprehensive prescriber or nurse monitoring	support and counselling smoking cessation programme, which includes
The patient has not had a Special Authority for varenicline ap	proved in the last 6 months acological smoking cessation treatments and the patient has agreed to
and this  The patient is not pregnant	
O The patient will not be prescribed more than 12 weeks' funded	d varenicline in a 12 month period

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Buprenorphine with naloxone	
INITIATION – Detoxification	
Prerequisites (tick boxes where appropriate)	
Patient is opioid dependent  and Patient is currently engaged with an opioid treatment service  and Prescriber works in an opioid treatment service approved by t	
INITIATION – Maintenance treatment	
Prerequisites (tick boxes where appropriate)	
Patient is opioid dependent  and Patient will not be receiving methadone  and Patient is currently enrolled in an opioid substitution treatment and Prescriber works in an opioid treatment service approved by the	

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Signed.	Date:	
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#### **Oncology Agents and Immunosuppressants**



PRESCRIBER	PATIENT:
Name:	
Ward:	NHI:
Bendamustii	ne hydrochloride
INITIATION – C Prerequisites (	CLL* (tick boxes where appropriate)
and on and	The patient has chronic lymphocytic leukaemia requiring treatment  Patient has ECOG performance status 0-2  Bendamustine is to be administered at a maximum dose of 100 mg/m² on days 1 and 2 every 4 weeks for a maximum of 6 cycles  marked with a * includes indications that are unapproved. 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma
Re-assessment	ndolent, Low-grade lymphomas t required after 9 months (tick boxes where appropriate)
and	The patient has indolent low grade NHL requiring treatment  Patient has ECOG performance status of 0-2
	Patient is treatment naive and Bendamustine is to be administered for a maximum of 6 cycles (in combination with rituximab when CD20+)
or	Patient is refractory to or has relapsed within 12 months of a rituximab containing combined chemo-immunotherapy regimen  and  Bendamustine is to be administered in combination with obinutuzumab for a maximum of 6 cycles
or	The patient has not received prior bendamustine therapy  and  Bendamustine is to be administered for a maximum of 6 cycles in relapsed patients (in combination with rituximab when CD20+)
or	Patient has had a rituximab treatment-free interval of 12 months or more  Bendamustine is to be administered as monotherapy for a maximum of 6 cycles in rituximab refractory patients

I confirm that the above details are correct:

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

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Bendamustine hydrochloride - continued	
CONTINUATION – Indolent, Low-grade lymphomas Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)	
and	nin 12 months of rituximab in combination with bendamustine nbination with obinutuzumab for a maximum of 6 cycles
O Patients have not received a bendamustine and	e regimen within the last 12 months
rituximab when CD20+)  and Patient has had a rituximab tre	estered for a maximum of 6 cycles in relapsed patients (in combination with eatment-free interval of 12 months or more  as a monotherapy for a maximum of 6 cycles in rituximab refractory patients
Note: 'indolent, low-grade lymphomas' includes follicular, mantle	e cell, marginal zone and lymphoplasmacytic/ Waldenström's macroglobulinaemia.
INITIATION – Hodgkin's lymphoma* Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
Patient has Hodgkin's lymphoma requiring treatmand Patient has a ECOG performance status of 0-2 and	nent
Patient has received one prior line of chemothera	ару
Patient's disease relapsed or was refractory follo	owing prior chemotherapy
	ion with gemcitabine and vinorelbine (BeGeV) at a maximum dose of no greater than r cycles
Note: Indications marked with * are unapproved indications.	

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Azacitidine	
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by a haematologist, or in accordan Hospital.	ce with a protocol or guideline that has been endorsed by the Health NZ
or  The patient has chronic myelomonocytic leukaemia (10 or	m (IPSS) intermediate-2 or high risk myelodysplastic syndrome %-29% marrow blasts without myeloproliferative disorder) plasts and multi-lineage dysplasia, according to World Health Organisation
The patient has an estimated life expectancy of at least 3 more	nths
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
O No evidence of disease progression and O The treatment remains appropriate and patient is benefitting f	rom treatment

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PATIENT:
Name:
NHI:
ediatric oncologist, or in accordance with a protocol or guideline that has er day
ediatric oncologist, or in accordance with a protocol or guideline that has er day

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Lenalidomide			
INITIATION – Relapsed/refractory disease Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a haematologist, or in accordance Hospital.  Patient has relapsed or refractory multiple myeloma with progrand Patient has not previously been treated with lenalidomide and  Lenalidomide to be used as third line* treatment for multiple and  Lenalidomide to be used as second line treatment and	tiple myeloma		
thalidomide that precludes further treatment with and  Lenalidomide to be administered at a maximum dose of 25 mg  CONTINUATION – Relapsed/refractory disease Re-assessment required after 6 months  Prerequisites (tick boxes where appropriate)	either of these treatments		
No evidence of disease progression and The treatment remains appropriate and patient is benefitting fr	rom treatment		
Hospital.	plant (SCT)  ce with a protocol or guideline that has been endorsed by the Health NZ		
Patient has newly diagnosed symptomatic multiple myeloma a cell transplantation  and Patient has at least a stable disease response in the first 100 and Lenalidomide maintenance is to be commenced within 6 mont and Lenalidomide to be administered at a maximum dose of 15 mg	ths of transplantation		

I confirm that the above details are correct:

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

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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:
Lenalidomide - continued	
CONTINUATION – Maintenance following first-line autologous stem cell to Re-assessment required after 6 months  Prerequisites (tick boxes where appropriate)  Or Prescribed by, or recommended by a haematologist, or in accordance Hospital.	ce with a protocol or guideline that has been endorsed by the Health NZ
No evidence of disease progression  and  The treatment remains appropriate and patient is benefitting fr	rom treatment

Note: Indication marked with \* is an unapproved indication. A line of treatment is considered to comprise either: a) a known therapeutic chemotherapy regimen and supportive treatments or b) a transplant induction chemotherapy regimen, stem cell transplantation and supportive treatments. Prescriptions must be written by a registered prescriber in the lenalidomide risk management programme operated by the supplier.

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:	
ame:		
Ward:	NHI:	
Venetoclax		
INITIATION – relapsed/refractory chronic lymphocytic leukaet Re-assessment required after 7 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a haematologist, or Hospital.  and  Patient has chronic lymphocytic leukaemia require and  Patient has received at least one prior therapy for and  Patient has not previously received funded venetor and  The patient's disease has relapsed within 36 more and  Venetoclax to be used in combination with six 28-venetoclax	in accordance with a protocol or guideline that has been endorsed by the Health NZ ing treatment chronic lymphocytic leukaemia	
and Patient has an ECOG performance status of 0-2		
Hospital.	in accordance with a protocol or guideline that has been endorsed by the Health NZ patient is benefitting from and tolerating treatment	
	n of 24 months of treatment following the titration schedule unless earlier discontinuation ptable toxicity	
Hospital.  O Patient has previously untreated chronic lymphocal and	in accordance with a protocol or guideline that has been endorsed by the Health NZ	
Hospital.  The treatment remains clinically appropriate and the pa	in accordance with a protocol or guideline that has been endorsed by the Health NZ	

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

PRESC	RIBI	ER	PATIENT:
Name:			
Ward: .			NHI:
Olapaı	rib		
Re-ass	essr uisi	nent tes (	varian cancer required after 12 months ck boxes where appropriate) bed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ al.
	nd and	`	Patient has a high-grade serous* epithelial ovarian, fallopian tube, or primary peritoneal cancer There is documentation confirming pathogenic germline BRCA1 or BRCA2 gene mutation
		or	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
		OI .	Patient has received at least two lines** of previous treatment with platinum-based chemotherapy  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  Patient's disease must have experienced a partial or complete response to treatment with the immediately preceding platinum-based regimen  Patient has not previously received funded olaparib treatment
а	and and and	)	Treatment will be commenced within 12 weeks of the patient's last dose of the immediately preceding platinum-based regimen reatment to be administered as maintenance treatment reatment not to be administered in combination with other chemotherapy

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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:
Olaparib - continued	
CONTINUATION – Ovarian cancer Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a medical oncologist, or in ac Hospital.	cordance with a protocol or guideline that has been endorsed by the Health NZ
O Treatment remains clinically appropriate and patient is beneath	efitting from treatment
O No evidence of progressive disease	
	e patient would continue to benefit from treatment in the clinician's
and Treatment to be administered as maintenance treatment and	
Treatment not to be administered in combination with other	chemotherapy
Patient has received one line** of previous trea	tment with platinum-based chemotherapy
	been informed and acknowledges that the funded treatment period of the patient experiences a complete response to treatment and there is
O Patient has received at least two lines** of previous to	eatment 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:

PRESCRIE	BER	PATIENT:	
Name:		Name:	
Ward:		NHI:	
Ibrutinib	)		
Re-assess	Sment resistes (tid	chronic lymphocytic leukaemia (CLL) t required after 6 months (tick boxes where appropriate)  Patient has chronic lymphocytic leukaemia (CLL) requiring therapy  Patient has not previously received funded ibrutinib  Ibrutinib is to be used as monotherapy  There is documentation confirming that patient has 17p deletion and Patient has experienced intolerable side effects with venetoclation  Patient has received at least one prior immunochemotherapy for and Patient's CLL has relapsed within 36 months of previous treatment Patient has experienced intolerable side effects with venetoclation  Patient's CLL is refractory to or has relapsed within 36 months of a venetor of the control of the con	or CLL nent x in combination with rituximab regimen
Re-assess	sment resites (tio	N – chronic lymphocytic leukaemia (CLL) t required after 12 months (tick boxes where appropriate)  No evidence of clinical disease progression	
and	$\sim$	The treatment remains appropriate and the patient is benefitting from treati	ment
Note: 'Ch leukaemi	nronic ly ia (B-PL	lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL) a PLL)*. Indications marked with * are Unapproved indications.	nd B-cell prolymphocytic

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PRESCRIBER		PATIENT:	
lame:		Name:	
Vard:	NHI:		
liraparib			
	uired after 6 months poxes where appropriate)		
and Patie and Patie and Patie and  or  and  Trea and	Patient commenced treatment with niraparib prior to 1 M	um-based chemotherapy preceding treatment with platinum-based chemotherapy ARP inhibitor tient's last dose of the preceding platinum-based regimen ay 2024	
CONTINUATION Re-assessment requirement requisites (tick if the land)  No earth of the land	uired after 6 months coxes where appropriate)  evidence of progressive disease  tment to be administered as maintenance treatment tment not to be administered in combination with other che	emotherapy	

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:

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.

Schedule. For community funding, see the Special Authority Criteria.	
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Lenalidomide	
INITIATION – Plasma cell dyscrasia  Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by any relevant practitioner, or in a NZ Hospital.	accordance with a protocol or guideline that has been endorsed by the Health
Patient has plasma cell dyscrasia, not including Waldenström  Patient is not refractory to prior lenalidomide use	n macroglobulinaemia, requiring treatment
INITIATION – Myelodysplastic syndrome Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by any relevant practitioner, or in a NZ Hospital.	accordance with a protocol or guideline that has been endorsed by the Health
a deletion 5q cytogenetic abnormality	ome (based on IPSS or an IPSS-R score of less than 3.5) associated with
O Patient has transfusion-dependent anaemia	
CONTINUATION – Myelodysplastic syndrome Re-assessment required after 12 months  Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by any relevant practitioner, or in a NZ Hospital.	accordance with a protocol or guideline that has been endorsed by the Health
Patient has not needed a transfusion in the last 4 months and	
O No evidence of disease progression	

I confirm that the above details are correct:

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

PRES	SCRIBER	PATIENT:
Name	e:	Name:
Ward	b	NHI:
Pom	nalidomide	
	IATION – Relapsed/refractory plasma cell dyscrasia assessment required after 6 months	
Prer	requisites (tick boxes where appropriate)	
and	Prescribed by, or recommended by any relevant practitioner, or in ac NZ Hospital.	ecordance with a protocol or guideline that has been endorsed by the Health
	Patient has relapsed or refractory plasma cell dyscrasia, not in Patient has not received prior funded pomalidomide	ncluding Waldenström macroglobulinaemia, requiring treatment
Re-a	artinuation – Relapsed/refractory plasma cell dyscrasia assessment required after 12 months requisites (tick box where appropriate)	
and	O Prescribed by, or recommended by any relevant practitioner, or in ac NZ Hospital.	ecordance with a protocol or guideline that has been endorsed by the Health
and	O Patient has no evidence of disease progression	

Signed:	Date:	
oigneu.	 Date.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Temozolomide	
INITIATION – gliomas	
Re-assessment required after 12 months  Prerequisites (tick box where appropriate)  Patient has a glioma	
CONTINUATION – gliomas Re-assessment required after 12 months Prerequisites (tick box where appropriate)  Or Treatment remains appropriate and patient is benefitting from treatment.	nent
INITIATION – Neuroendocrine tumours Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)	
Patient has been diagnosed with metastatic or unresectable wand  Temozolomide is to be given in combination with capecitabine and  Temozolomide is to be used in 28 day treatment cycles for a new per day  and  Temozolomide to be discontinued at disease progression	
CONTINUATION – Neuroendocrine tumours Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O No evidence of disease progression and O The treatment remains appropriate and the patient is benefitting	ng from treatment
INITIATION – ewing's sarcoma Re-assessment required after 9 months Prerequisites (tick box where appropriate)  O Patient has relapse or refractory Ewing's sarcoma	
CONTINUATION – ewing's sarcoma Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  No evidence of disease progression	
and  The treatment remains appropriate and the patient is benefitting	ng from treatment
Note: Indication marked with a * is an unapproved indication. Temozolomic relapsed high grade glioma.	de is not funded for the treatment of

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Thalidomide		
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)  Or The patient has plasma cell dyscrasia, not including Waldenst or The patient has erythema nodosum leprosum	rröm macroglobulinaemia, requiring treatment	
CONTINUATION Prerequisites (tick box where appropriate)  O Patient has obtained a response from treatment during the initial approval period Note: Prescription must be written by a registered prescriber in the thalidomide risk management programme operated by the supplier Maximum dose of 400 mg daily as monotherapy or in a combination therapy regimen		

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Signed.	Date:	
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#### Form RS2043 January 2025

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:	
Bortezomib		
INITIATION – plasma cell dyscrasia Prerequisites (tick box where appropriate)		
O The patient has plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment		

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pegaspargase	
INITIATION – Newly diagnosed ALL Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)  The patient has newly diagnosed acute lymphoblastic leukaem and Pegaspargase to be used with a contemporary intensive multi-	
INITIATION – Relapsed ALL	
Re-assessment required after 12 months  Prerequisites (tick boxes where appropriate)	
The patient has relapsed acute lymphoblastic leukaemia and Pegaspargase to be used with a contemporary intensive multi-	agent chemotherapy treatment protocol
INITIATION – Lymphoma Re-assessment required after 12 months Prerequisites (tick box where appropriate)  O Patient has lymphoma requiring L-asparaginase containing protocol	(e.g. SMILE)

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PRESCRIBER	PATIENT:	
ame:		
Vard: NHI:		
Nilotinib		
Hospital.	ce with a protocol or guideline that has been endorsed by the Health NZ	
Patient has a diagnosis of chronic myeloid leukaemia (CML) i	n blast crisis, high risk chronic phase, or in chronic phase	
or  Patient has documented CML treatment failure* with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient limiting toxicity with a s	a tyrosine kinase inhibitor (TKI) precluding further treatment	
and  Maximum nilotinib dose of 800 mg/day and  Subsidised for use as monotherapy only		
Note: *treatment failure as defined by Leukaemia Net Guidelines.		
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a haematologist, or in accordant Hospital.  and	ce with a protocol or guideline that has been endorsed by the Health NZ	
C Lack of treatment failure while on nilotinib as defined by Leuk and Nilotinib treatment remains appropriate and the patient is ben		
and  Maximum nilotinib dose of 800 mg/day and  Subsidised for use as monotherapy only	enung nom deaunent	

I confirm that the above details are correct:	
Signed:	Date:

PRESCI	RIBI	ER		PATIENT:
Name:				Name:
Ward: .				NHI:
Ruxoli	tini	b		
	essr	nent	t required after 12 months (tick boxes where appropriate)	
and		resc ospi		e with a protocol or guideline that has been endorsed by the Health NZ
	nd (	)	The patient has primary myelofibrosis or post-polycythemia ver	ra myelofibrosis or post-essential thrombocythemia myelofibrosis
		or	System (IPSS), Dynamic International Prognostic Scorin	usis according to either the International Prognostic Scoring System
				are resistant, refractory or intolerant to available therapy
а	nd (	)	A maximum dose of 20 mg twice daily is to be given	
	essr	nent	t required after 12 months (tick boxes where appropriate)	
a	nd	)	The treatment remains appropriate and the patient is benefiting	g from treatment
		ر 	A maximum dose of 20 mg twice daily is to be given	

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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:		
Alectinib			
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  O Patient has locally advanced, or metastatic, unresectable, nor and O There is documentation confirming that the patient has an ALI and O Patient has an ECOG performance score of 0-2	n-small cell lung cancer  K tyrosine kinase gene rearrangement using an appropriate ALK test		
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)			
No evidence of progressive disease according to RECIST crite and The patient is benefitting from and tolerating treatment	eria		

Signed:	Date:	
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PRESCRI	ESCRIBER PATIENT:				
Name:	ne:Name:				
Ward:	d:NHI:				
Palbocio	elib (lbra	ance)			
	sment req	uired after 6 months boxes where appropriate)			
or	and and o	Patient has unresectable locally advanced or metastatic breast cancer  There is documentation confirming disease is hormone-receptor positive and HER2-negative  Patient has an ECOG performance score of 0-2  O Disease has relapsed or progressed during prior endocrine therapy  O Patient is amenorrhoeic, either naturally or induced, with endocrine levels consistent with a postmenopausal or without menstrual-potential state  O Patient has not received prior systemic treatment for metastatic disease  Treatment must be used in combination with an endocrine partner  Patient has not received prior funded treatment with a CDK4/6 inhibitor			
	and and and	Patient has an active Special Authority approval for ribociclib  Patient has experienced a grade 3 or 4 adverse reaction to ribociclib that cannot be managed by dose reductions and requires treatment discontinuation  Treatment must be used in combination with an endocrine partner  There is no evidence of progressive disease since initiation of ribociclib			
	sment req	uired after 12 months boxes where appropriate) atment must be used in combination with an endocrine partner			
	<b>○</b> The	re is no evidence of progressive disease since initiation of palbociclib			

I confirm that the above details are correct:	
Signed:	Date:

PRES	CRIBER		PATIENT:
Name	:		Name:
Ward			NHI:
Mido	staurin		
	and and	(tick boxes where appropriate)  Patient has a diagnosis of acute myeloid leukaemia  Condition must be FMS tyrosine kinase 3 (FLT3) mutation pos  Patient must not have received a prior line of intensive chemot	
	and	Patient is to receive standard intensive chemotherapy in comb  Midostaurin to be funded for a maximum of 4 cycles	ination with midostaurin only

PRESCRIBER	PATIENT:	
ame:Name:		
Ward:	NHI:	
Ribociclib		
Ribociclib  INITIATION Re-assessment requivalence (tick by and and and or and or and or and or and or and and and or	Patient has unresectable locally advanced or metastatic breast cancer  There is documentation confirming disease is hormone-receptor positive and HER2-negative  Patient has an ECOG performance score of 0-2  Disease has relapsed or progressed during prior endocrine therapy  Patient is amenorrhoeic, either naturally or induced, with endocrine levels consistent with a postmenopausal or without menstrual-potential state  Patient has not received prior systemic endocrine treatment for metastatic disease  Patient commenced treatment with ribociclib in combination with an endocrine partner prior to 1 July 2024  There is no evidence of progressive disease	
and on and	Treatment to be used in combination with an endocrine partner  Patient has not received prior funded treatment with a CDK4/6 inhibitor	
or  and and and and	Patient has an active Special Authority approval for palbociclib  Patient has experienced a grade 3 or 4 adverse reaction to palbociclib that cannot be managed by dose reductions and requires treatment discontinuation  Treatment must be used in combination with an endocrine partner  There is no evidence of progressive disease since initiation of palbociclib	
O Treat	ired after 12 months oxes where appropriate) ment must be used in combination with an endocrine partner e is no evidence of progressive disease since initiation of ribociclib	

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	3	PATIENT:
Name:		Name:
Ward:		NHI:
Lenvatinib		
Re-assessme	- thyroid cancer ent required after 6 months s (tick boxes where appropriate)	
O	Patient is currently on treatment with lenvatinib and met all rema	ining criteria prior to commencing treatment
or	O The patient has locally advanced or metastatic differentiat	ed thyroid cancer
ai	O Patient must have symptomatic progressive disease	prior to treatment
	Patient must progressive disease at critical anatomicannot be achieved by other measures	cal sites with a high risk of morbidity or mortality where local control
ar	and C	
	Or A lesion without iodine uptake in a RAI scan	
	O Receiving cumulative RAI greater than or equal to 6	00 mCi
	O Experiencing disease progression after a RAI treatm	nent within 12 months
		atments administered within 12 months of each other
	Patient has thyroid stimulating hormone (TSH) adequately	supressed
	O Patient is not a candidate for radiotherapy with curative int	ent
ar	Surgery is clinically inappropriate	
ar	Patient has an ECOG performance status of 0-2	
Re-assessme	ION – thyroid cancer ent required after 6 months s (tick box where appropriate)	
O Ther	ere is no evidence of disease progression	
Re-assessme	- unresectable hepatocellular carcinoma ent required after 6 months s (tick boxes where appropriate)	
O	Patient has unresectable hepatocellular carcinoma	
and	Patient has preserved liver function (Childs-Pugh A)	
and	Transarterial chemoembolisation (TACE) is unsuitable	
and	Patient has an ECOG performance status of 0-2	
and	Patient has not received prior systemic therapy for their disease	in the palliative setting

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Lenvatinib - continued	
CONTINUATION – unresectable hepatocellular carcinoma Re-assessment required after 6 months	
Prerequisites (tick box where appropriate)  O There is no evidence of disease progression	
INITIATION – renal cell carcinoma Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	
The patient has metastatic renal cell carcinoma  and The disease is of predominant clear-cell histology and The patient has documented disease progression follow and The patient has an ECOG performance status of 0-2 and Lenvatinib is to be used in combination with everolimus  or  Patient has received funded treatment with nivolumab for and Patient has experienced treatment limiting toxicity from and Lenvatinib is to be used in combination with everolimus and There is no evidence of disease progression	or the second line treatment of metastatic renal cell carcinoma treatment with nivolumab
CONTINUATION – renal cell carcinoma Re-assessment required after 4 months Prerequisites (tick box where appropriate)	
O There is no evidence of disease progression	

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I confirm that the above details are correct:

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

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	i:NHI:		
Osimertinib			
Re-assessmen	NSCLC – first line  It required after 4 months (tick boxes where appropriate)		
and or or and oand	Patient has locally advanced or metastatic, incurable, non-squamous non-small cell lung cancer (NSCLC)  Patient is treatment naïve  Patient has received prior treatment in the adjuvant setting and/or while awaiting EGFR results  The patient has discontinued gefitinib or erlotinib due to intolerance and  The cancer did not progress while on gefitinib or erlotinib  There is documentation confirming that the cancer expresses activating mutations of EGFR  Patient has an ECOG performance status 0-3  Baseline measurement of overall tumour burden is documented clinically and radiologically		
Re-assessmen Prerequisites Resp recer  INITIATION – I Re-assessmen	ON – NSCLC – first line It required after 6 months (tick box where appropriate) It reads to or stable disease with treatment in target lesions has been determined by comparable radiologic assessment following the most at treatment period  NSCLC – second line It required after 4 months  (tick boxes where appropriate)		
and and and and and and and and	Patient has locally advanced or metastatic, incurable, non-squamous non-small cell lung cancer (NSCLC)  Patient has an ECOG performance status 0-3  The patient must have received previous treatment with erlotinib or gefitinib  There is documentation confirming that the cancer expresses T790M mutation of EGFR following progression on or after erlotinib or gefitinib  The treatment must be given as monotherapy  Baseline measurement of overall tumour burden is documented clinically and radiologically		
Re-assessment Prerequisites	ON – NSCLC – second line It required after 6 months (tick box where appropriate) It reads to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment d		

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Dasatinib	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a haematologist or any relevant with a protocol or guideline that has been endorsed by the Health N and	practitioner on the recommendation of a haematologist, or in accordance Z Hospital.
The patient has a diagnosis of chronic myeloid leukaemia (CN or Or The patient has a diagnosis of Philadelphia chromosome-position	
The patient has a diagnosis of CML in chronic phase	
O Patient has documented treatment failure* with im	natinib
	with imatinib precluding further treatment with imatinib
O Patient has high-risk chronic-phase CML defined	by the Sokal or EURO scoring system
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a haematologist or any relevant with a protocol or guideline that has been endorsed by the Health N	practitioner on the recommendation of a haematologist , or in accordance Z Hospital.
C Lack of treatment failure while on dasatinib*	
O Dasatinib treatment remains appropriate and the patient is be	nefiting from treatment
Note: *treatment failure for CML as defined by Leukaemia Net Guidelines.	

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Erlotinib	
INITIATION Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)  O Patient has locally advanced or metastatic, unresectable, nonand There is documentation confirming that the disease expresses and O Patient is treatment naive or O Patient has received prior treatment in the adjuvant setting or The patient has discontinued osimertinib or getiting and The cancer did not progress while on osimertinib or	activating mutations of EGFR  ng and/or while awaiting EGFR results  ib due to intolerance
CONTINUATION Re-assessment required after 6 months Prerequisites (tick box where appropriate)  O Radiological assessment (preferably including CT scan) indicates NS	SCLC has not progressed

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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.

PRESC	RIBER	R PATIENT:	
Name:			
Ward:		NHI:	
Suniti	nib		
	sessme	<ul> <li>RCC</li> <li>ent required after 3 months</li> <li>es (tick boxes where appropriate)</li> </ul>	
	and	The patient has metastatic renal cell carcinoma	
		O The patient is treatment naive	
		The patient has only received prior cytokine treatment	
		The patient has only received prior treatment with an investigational agent within the confines of a bona fide clinical trial whas Ethics Committee approval	nich
		O The patient has discontinued pazopanib within 3 months of starting treatment due to intolerance and	
		The cancer did not progress whilst on pazopanib	
Note:	and O	The patient has good performance status (WHO/ECOG grade 0-2) The disease is of predominant clear cell histology  Lactate dehydrogenase level > 1.5 times upper limit of normal Haemoglobin level < lower limit of normal Corrected serum calcium level > 10 mg/dL (2.5 mmol/L) Interval of < 1 year from original diagnosis to the start of systemic therapy  Karnofsky performance score of less than or equal to 70 2 or more sites of organ metastasis  Sunitinib to be used for a maximum of 2 cycles  Sunitinib treatment should be stopped if disease progresses. sis patients are defined as having at least 3 of criteria 5.1-5.6. Intermediate prognosis patients are defined as having 1 or 2 of criteria	a 5.1-5.6.
Re-ass	sessme	rion – RCC ent required after 3 months es (tick boxes where appropriate)	
í	and	No evidence of disease progression	
	$\circ$	The treatment remains appropriate and the patient is benefiting from treatment	

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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:
Sunitinib - continued	
INITIATION – GIST Re-assessment required after 3 months Prerequisites (tick boxes where appropriate)	
The patient has unresectable or metastatic malignant gastro	intestinal stromal tumour (GIST)
O The patient's disease has progressed following treatm	ent with imatinib
O The patient has documented treatment-limiting intolera	ance, or toxicity to, imatinib
follows:  The patient has had a complete response (disappeara or The patient has had a partial response (a decrease in (HU) of 15% or more on CT and no new lesions and no	size of 10% or more or decrease in tumour density in Hounsfield Units o obvious progression of non-measurable disease) the two above) and does not have progressive disease and no
O The treatment remains appropriate and the patient is benefit	ing from treatment
CONTINUATION – GIST pandemic circumstances Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
The patient has unresectable or metastatic malignant gastro and The patient is clinically benefiting from treatment and continuand Sunitinib is to be discontinued at progression and The regular renewal requirements cannot be met due to CO	ued treatment remains appropriate

Note: GIST - It is recommended that response to treatment be assessed using Choi's modified CT response evaluation criteria (J Clin Oncol, 2007, 25:1753-1759). Progressive disease is defined as either: an increase in tumour size of 10% or more and not meeting criteria of partial response (PR) by tumour density (HU) on CT; or: new lesions, or new intratumoral nodules, or increase in the size of the existing intratumoral nodules.

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Lapatinib	
INITIATION Prerequisites (tick box where appropriate)  O For continuation use only	
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
The patient has metastatic breast cancer expressing HER-2 III and The cancer has not progressed at any time point during the properties of the cancer has not progressed at any time point during the properties of the cancer has not progressed at any time point during the properties of the cancer has not progressed at any time point during the properties of the cancer has not progressed at any time point during the properties of the cancer has not progressed at any time point during the properties of the cancer expressing HER-2 III.	

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:
Pazopanib	
	at required after 3 months (tick boxes where appropriate)
and	The patient has metastatic renal cell carcinoma
or	O The patient is treatment naive
or	O The patient has only received prior cytokine treatment
	O The patient has discontinued sunitinib within 3 months of starting treatment due to intolerance and
	O The cancer did not progress whilst on sunitinib
and and and	The patient has good performance status (WHO/ECOG grade 0-2)  The disease is of predominant clear cell histology
an	C Lactate dehydrogenase level > 1.5 times upper limit of normal
an	
an	Corrected serum calcium level > 10 mg/dL (2.5 mmol/L)  d Interval of < 1 year from original diagnosis to the start of systemic therapy
an	
an	
	on trequired after 3 months (tick boxes where appropriate)
and	No evidence of disease progression
	The treatment remains appropriate and the patient is benefiting from treatment
Poor prognos	unib treatment should be stopped if disease progresses. is patients are defined as having at least 3 of criteria 5.1-5.6. Intermediate prognosis patients are ving 1 or 2 of criteria 5.1-5.6.

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Gefitinib		
INITIATION Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)		
Patient has locally advanced, or metastatic, unresectable, not	n-squamous Non Small Cell Lung Cancer (NSCLC)	
Patient is treatment naive  Or Patient has received prior treatment in the adjuvant sett  or  The patient has discontinued osimertinib or erloting and The cancer did not progress whilst on osimertinib	nib due to intolerance	
There is documentation confirming that disease expresses activating mutations of EGFR		
CONTINUATION Re-assessment required after 6 months Prerequisites (tick box where appropriate)  O Radiological assessment (preferably including CT scan) indicates N	SCLC has not progressed	

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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.

PRES	CRIB	ER			PATIENT:
Name	:				Name:
Ward					NHI:
Dexi	azox	ane	<b>)</b>		
	Э р	tes (	ribed by, o	s where appropriate) or recommended by a medical oncologist, paediatric of ideline that has been endorsed by the Health NZ Hos	encologist, haematologist or paediatric haematologist, or in accordance with pital.
	and (	C		to receive treatment with high dose anthracycline give current treatment plan, patient's cumulative lifetime d	en with curative intent lose of anthracycline will exceed 250mg/m2 doxorubicin equivalent or
	and	C	Dexrazoxa	ane to be administered only whilst on anthracycline tre	eatment
		or	O Trea	atment to be used as a cardioprotectant for a child or	young adult
			O Trea	atment to be used as a cardioprotectant for secondary	y malignancy

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Abiraterone acetate	
been endorsed by the Health NZ Hospital.	oncologist or urologist, or in accordance with a protocol or guideline that has
Patient has prostate cancer and Patient has metastases and Patient's disease is castration resistant and	
Patient is symptomatic  and Patient has disease progression (rising serum PS and Patient has ECOG performance score of 0-1 and Patient has not had prior treatment with taxane ch  or  Patient's disease has progressed following prior chand Patient has ECOG performance score of 0-2 and Patient has not had prior treatment with abirateror	hemotherapy containing a taxane
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
been endorsed by the Health NZ Hospital.	encologist or urologist, or in accordance with a protocol or guideline that has
O Significant decrease in serum PSA from baseline and	
O No evidence of clinical disease progression and	
O No initiation of taxane chemotherapy with abiraterone and	
The treatment remains appropriate and the patient is benefiting	ng from treatment

I confirm that the above details are correct:

PRES	CRIBER		PATIENT:
Name	e:		Name:
Ward	:		NHI:
Abir	aterone	acetate - continued	
Re-a	equisites	ON – pandemic circumstances  It required after 6 months (tick boxes where appropriate)  The patient is clinically benefiting from treatment and continued	d treatment remains appropriate
	and and and	Abiraterone acetate to be discontinued at progression  No initiation of taxane chemotherapy with abiraterone  The regular renewal requirements cannot be met due to COVII	D-19 constraints on the health sector

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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.

PRES	CRIBER		PATIENT:
Name	e:		Name:
Ward	:		NHI:
Fulv	estrant		
Re-a	Prescribe Hospital.  Pand Pand Pand Treand	tient has oestrogen-receptor positive locally advanced or me	an aromatase inhibitor or tamoxifen for their locally advanced or
Re-a	equisites (tick		dance with a protocol or guideline that has been endorsed by the Health NZ
und	and Tre	eatment remains appropriate and patient is benefitting from to be given at a dose of 500 mg monthly be evidence of disease progression	reatment

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Signeg	 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.

contended. For community funding, see the operat Authority Official.	
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Octreotide	
INITIATION – Malignant bowel obstruction Prerequisites (tick boxes where appropriate)	
The patient has nausea* and vomiting* due to malignant bowe and Treatment with antiemetics, rehydration, antimuscarinic agents and Octreotide to be given at a maximum dose 1500 mcg daily for	s, corticosteroids and analgesics for at least 48 hours has failed
Note: Indications marked with * are unapproved indications	
INITIATION – acromegaly Re-assessment required after 3 months Prerequisites (tick boxes where appropriate)	
The patient has acromegaly	
O Treatment with surgery, radiotherapy and a dopamine aç	gonist has failed
O Treatment with octreotide is for an interim period while a	waiting the effects of radiotherapy and a dopamine agonist has failed
The patient is unwilling, or unable, to undergo surgery a	nd/or radiotherapy
CONTINUATION – acromegaly Prerequisites (tick boxes where appropriate)	
IGF1 levels have decreased since starting octreotide	
O The treatment remains appropriate and the patient is benefiting	g from treatment
Note: In patients with acromegaly octreotide treatment should be discontinued treated with radiotherapy octreotide treatment should be withdrawn every 2 ye be stopped where there is biochemical evidence of remission (normal IGF1 levidence).	ars, for 1 month, for assessment of remission. Octreotide treatment should
I confirm that the above details are correct:	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Octreotide - continued	
INITIATION – Other indications Prerequisites (tick boxes where appropriate)	
O VIPomas and glucagonomas - for patients who are serio	ously ill in order to improve their clinical state prior to definitive surgery
Gastrinoma and	
O Patient has failed surgery	
Patient in metastatic disease after H2 antag	onists (or proton pump inhibitors) have failed
O Insulinomas	
O Surgery is contraindicated or has failed	
or  For pre-operative control of hypoglycaemia and for main  or	tenance therapy
Carcinoid syndrome (diagnosed by tissue patholog	gy and/or urinary 5HIAA analysis)
O Disabling symptoms not controlled by maximal me	edical therapy
Note: restriction applies only to the long-acting formulations of octreotid	е
INITIATION – pre-operative acromegaly Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
O Patient has acromegaly and	
Patient has a large pituitary tumour, greater than 10 mm	at its widest
O Patient is scheduled to undergo pituitary surgery in the r	next six months
Note: Indications marked with * are unapproved indications	
CONTINUATION – Acromegaly - pandemic circumstances Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
Patient has acromegaly and	
The patient is clinically benefiting from treatment and co	ntinued treatment remains appropriate
The regular renewal requirements cannot be met due to	COVID-19 constraints on the health sector

I confirm that the above details are correct:

PRES	CRIBER		PATIENT:			
Name	e:		Name:			
Ward	:		NHI:			
Amir	nolevuli	nic acid hydrochloride				
1		nigh grade malignant glioma (tick boxes where appropriate)				
	O	Patient has newly diagnosed, untreated, glioblastoma multiform	те			
	and	ction				
O Patient's tumour is amenable to complete resection						

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Oigilica.	 Duic.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Tacrolimus	
INITIATION – organ transplant recipients Prerequisites (tick box where appropriate)  O Prescribed by, or recommended by any specialist, or in accordance of Hospital.  and O For use in organ transplant recipients  INITIATION – non-transplant indications* Prerequisites (tick boxes where appropriate)	with a protocol or guideline that has been endorsed by the Health NZ with a protocol or guideline that has been endorsed by the Health NZ
Patient requires long-term systemic immunosuppression  O Ciclosporin has been trialled and discontinued treatment or O Patient is a child with nephrotic syndrome*  Note: Indications marked with * are unapproved indications	t because of unacceptable side effects or inadequate clinical response

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Oigilica.	 Duic.	

#### RS2062 - Etanercept

Arthritis - rheumatoid - INITIATION	
Arthritis - rheumatoid - CONTINUATION	309
Adult-onset Still's disease - INITIATION	
Adult-onset Still's disease - CONTINUATION	
Ankylosing spondylitis - INITIATION	310
Ankylosing spondylitis - CONTINUATION	311
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Oligoarticular course juvenile idiopathic arthritis - CONTINUATION	308
Polyarticular course juvenile idiopathic arthritis - INITIATION	307
Polyarticular course juvenile idiopathic arthritis - CONTINUATION	307
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Psoriatic arthritis - CONTINUATION	312
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Pyoderma gangrenosum - CONTINUATION	
Severe chronic plaque psoriasis - CONTINUATION	314
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Undifferentiated spondyloarthritis - INITIATION	316
Undifferentiated spondyloarthritis - CONTINUATION	316

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.

PRES	SCRIB	BER		PATIENT:
Name	e:			
Ward	:			NHI:
Etan	erce	pt		
Re-a	ssess <b>equis</b>	ment ites ( Presc	requ tick b	ticular course juvenile idiopathic arthritis ired after 6 months oxes where appropriate)  by, or recommended by a rheumatologist or named specialist, or in accordance with a protocol or guideline that has been endorsed th NZ Hospital.
		and	O I	The patient has had an initial Special Authority approval for adalimumab for polyarticular course juvenile idiopathic arthritis (JIA)
			or	The patient has experienced intolerable side effects from adalimumab     The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for polyarticular course JIA
	or	and	0	To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance  Patient has had polyarticular course JIA for 6 months duration or longer  O At least 5 active joints and at least 3 joints with limited range of motion, pain or tenderness after a 3-month trial of methotrexate (at the maximum tolerated dose)  O Moderate or high disease activity (cJADAS10 score of at least 2.5) after a 3-month trial of methotrexate (at the maximum tolerated dose)  O Low disease activity (cJADAS10 score between 1.1 and 2.5) after a 6-month trial of methotrexate
Re-a	ssess	ment	requ	olyarticular course juvenile idiopathic arthritis ired after 6 months oxes where appropriate)
and				by, or recommended by a rheumatologist or named specialist, or in accordance with a protocol or guideline that has been endorsed th NZ Hospital.
	and	ment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or prance		
		or	0	Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baseline  On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline

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	BER		PATIENT:	PATIENT:		
Name:						
Ward:			NHI:			
Etanerc	ept -	- contin	tinued			
Re-asses Prerequi	sites Preso	t requir (tick bo cribed b	articular course juvenile idiopathic arthritis uired after 6 months boxes where appropriate) d by, or recommended by a rheumatologist or named specialist, or in accordance with a protocol or guideline that has been end alth NZ Hospital.	orsed		
	and		The patient has had an initial Special Authority approval for adalimumab for oligoarticular course juvenile idiopathic arthritis (JIA)			
		or	The patient has experienced intolerable side effects from adalimumab  The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for oligoarticular course JIA			
or	and	O	O Moderate or high disease activity (cJADAS10 score greater than 1.5) with poor prognostic features after a 3-month trial of methotrexate (at the maximum tolerated dose)			
Re-asses Prerequi	sites Presc	t requir (tick bo cribed b	oligoarticular course juvenile idiopathic arthritis uired after 6 months boxes where appropriate) d by, or recommended by a rheumatologist or named specialist, or in accordance with a protocol or guideline that has been end alth NZ Hospital.	orsed		
and	O	Subsid	sidised as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance			
	or	0	Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baselinee  On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline	1		

I confirm that the above details are correct:

I confirm that the above details are correct:

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

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRES	SCRIE	BER			PATIENT:		
Name	Name:						
Ward	Nard:NHI:						
Etan	erce	pt -	contii	nued			
INIT Re-a	IATIO assess	N – Ai	r <b>thrit</b> requi	is - rh red af	reumatoid ter 6 months where appropriate)		
and		Prescr Hospit		by, or	recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ		
		and	O	The p	patient has had an initial Special Authority approval for adalimumab for rheumatoid arthritis		
			or	0	The patient has experienced intolerable side effects		
				$\bigcirc$	The patient has received insufficient benefit to meet the renewal criteria for rheumatoid arthritis		
	or	and	0		nt has had rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic citrullinated peptide (CCP) ody positive) for six months duration or longer		
		and	0		ment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity olerance		
		and	$\bigcirc$		nt has tried and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated)		
		and	$\bigcirc$		nt has tried and not responded to at least three months of methotrexate in combination with sulfasalazine and hydroxychloroquin ate at maximum tolerated doses (unless contraindicated)		
			or	О	Patient has tried and not responded to at least three months of methotrexate in combination with the maximum tolerated dose of ciclosporin		
			<u> </u>	0	Patient has tried and not responded to at least three months of therapy at the maximum tolerated dose of leflunomide alone or in combination with methotrexate		
		and		0	Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen joints		
			or	0	Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip		
Re-a	assess	ment	requi	red af	s - rheumatoid ter 2 years vhere appropriate)		
and		Prescr NZ Ho			recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health		
	Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance						
		or	0		wing initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant onse to treatment in the opinion of the physician		
			0		ubsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count from ine and a clinically significant response to treatment in the opinion of the physician		
	and	O 1	Etane	ercept	to be administered at doses no greater than 50 mg every 7 days		

PRES	CRIB	ER		PATIENT:	
Name	:			Name:	
Ward:				NHI:	
Etan	erce	pt -	conti	nued	
Re-a	ssess <b>equis</b> i	ment <b>ites</b> (t	requick b	sing spondylitis red after 6 months oxes where appropriate) by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ  The patient has had an initial Special Authority approval for adalimumab for ankylosing spondylitis  The patient has experienced intolerable side effects from adalimumab	
			or	O The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for ankylosing spondylitis	
	or	and and and	O O O O O O	Patient has a confirmed diagnosis of ankylosing spondylitis present for more than six months  Patient has low back pain and stiffness that is relieved by exercise but not by rest  Patient has bilateral sacroillitis demonstrated by plain radiographs, CT or MRI scan  Patient's ankylosing spondylitis has not responded adequately to treatment with two or more non-steroidal anti-inflammatory drugs (NSAIDs), in combination with anti-ulcer therapy if indicated, while patient was undergoing at least 3 months of a regular exercise regimen for ankylosing spondylitis  Patient has limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by the following Bath Ankylosing Spondylitis Metrology Index (BASMI) measures: a modified Schober's test of less than or equal to 4 cm and lumbar side flexion measurement of less than or equal to 10 cm (mean of left and right)  Patient has limitation of chest expansion by at least 2.5 cm below the average normal values corrected for age and gender (see Notes)	`
		and	0	Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) of at least 6 on a 0-10 scale	
meas	sure m	nust b ormal	e no	4 7.5 cm 5.5 cm 4 6.5 cm 4.5 cm 4 6.0 cm 5.0 cm 4 5.5 cm 4.0 cm	<i>)</i>

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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:						
Ward:			NHI:			
Etanerc	ept - d	conti	inued			
Re-asses	sment	requi	inkylosing spondylitis ired after 6 months			
Prerequi	equisites (tick boxes where appropriate)					
and	by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ					
and	р		wing 12 weeks' initial treatment and for subsequent renewals, treatment has resulted in an improvement in BASDAI of 4 or more s from pre-treatment baseline on a 10 point scale, or an improvement in BASDAI of 50%, whichever is less			
Physician considers that the patient has benefited from treatment and that continued treatment is appropriate  and						
	О	tane	ercept to be administered at doses no greater than 50 mg every 7 days			
Re-asses Prerequia	atic arthritis  iired after 6 months  boxes where appropriate)  by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ					
and	The patient has had an initial Special Authority approval for adalimumab or secukinumab for psoriatic arthritis					
	The patient has experienced intolerable side effects from adalimumab or secukinumab  The patient has received insufficient benefit from adalimumab or secukinumab to meet the renewal criteria for adalimumab or secukinumab for psoriatic arthritis					
or	and and	or or or	Patient has had severe active psoriatic arthritis for six months duration or longer  Patient has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a maximum tolerated dose  Patient has tried and not responded to at least three months of sulfasalazine at a dose of at least 2 g per day or leflunomide at a dose of up to 20 mg daily (or maximum tolerated doses)  Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen, tender joints  Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip  Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application  Patient has an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour  ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months			

I confirm that the above details are correct:

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.

PRES	CRIE	BER			PATIENT:
Name	e:				Name:
Ward:	:				NHI:
Etan	erce	pt ·	- conti	inued	
Re-a	ssess	men	t requ	osoriatic arthritis prized after 6 months proxes where appropriate)	
and		Preso Hosp		by, or recommended by a rheumatologist, or in accordance	ce with a protocol or guideline that has been endorsed by the Health NZ
		or	0	Following 3 to 4 months' initial treatment, the patient has clinically significant response to treatment in the opinion	s at least a 50% decrease in active joint count from baseline and a of the physician
			0	The patient demonstrates at least a continuing 30% impresponse to prior etanercept treatment in the opinion of t	ovement in active joint count from baseline and a clinically significant he treating physician
	and	0	Etan	ercept to be administered at doses no greater than 50 mg	every 7 days
				e chronic plaque psoriasis, prior TNF use lired after 4 months	
Prer	equis	ites	(tick b	poxes where appropriate)	
and		Preso Hosp		by, or recommended by a dermatologist, or in accordance	with a protocol or guideline that has been endorsed by the Health NZ
	and	O	The	patient has had an initial Special Authority approval for add	alimumab for severe chronic plaque psoriasis
			0	The patient has experienced intolerable side effects from	adalimumab
		or	0	The patient has received insufficient benefit from adalimuplaque psoriasis	umab to meet the renewal criteria for adalimumab for severe chronic
	and	0	Patie	ent must be reassessed for continuation after 3 doses	

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PKE	SCRIE	SEK		PATIENT:				
Name	e:			Name:				
Ward	:			NHI:				
Etan	erce	pt -	cont	ontinued				
				vere chronic plaque psoriasis, treatment-naive				
				equired after 4 months ck boxes where appropriate)				
	$\overline{}$							
and		Preso Hosp		ped by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed l.	by the Health NZ			
			0	Patient has "whole body" severe chronic plaque psoriasis with a Psoriasis Area and Severity Index (PASI) scor 10, where lesions have been present for at least 6 months from the time of initial diagnosis	e of greater than			
Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis  Patient has severe chronic localised genital or flexural plaque psoriasis where the plaques or lesions have been present for at least 6 months from the time of initial diagnosis, and with a Dermatology Life Quality Index (DLQI) score greater than 10								
							Patient has tried, but had an inadequate response (see Note) to, or has experienced intolerable side effects from, at least three following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, ciclosporin, or acitretin	
	and	0	treati	PASI assessment or Dermatology Quality of Life Index (DLQI) assessment has been completed for at least the moleatment course (but preferably all prior treatment courses), preferably while still on treatment but no longer than 1 essation of each prior treatment course				
	O The most recent PASI or DLQI assessment is no more than 1 month old at the time of initiation							
while face seve	e still o , hand ere, an	on tre I, foo Id for	atme t, gen the fa	e response" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 10, as assement but no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque genital or flexural areas at least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated e face, palm of a hand or sole of a foot the skin area affected is 30% or more of the face, palm of a hand or sole of till on treatment but no longer than 1 month following cessation of the most recent prior treatment.	osoriasis of the as severe or very			

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PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Etanercept - continued				
CONTINUATION – severe chronic plaque psoriasis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)				
O Patient had "whole body" severe chronic plaque	ue psoriasis at the start of treatment			
Following each prior etanercept treatme more, or is sustained at this level, when Following each prior etanercept treatme	ent course the patient has a PASI score which is reduced by 75% or compared with the pre-etanercept treatment baseline value ent course the patient has a Dermatology Quality of Life Index (DLQI) ared with the pre-treatment baseline value			
or				
O Patient had severe chronic plaque psoriasis o	f the face, or palm of a hand or sole of a foot at the start of treatment			
Following each prior etanercept treatme for all 3 of erythema, thickness and sca treatment course baseline values	ent course the patient has a reduction in the PASI symptom subscores ling, to slight or better, or sustained at this level, as compared to the			
	ent course the patient has a reduction of 75% or more in the skin area ompared to the pre-etanercept treatment baseline value			
or				
Patient had severe chronic localised genital or	r flexural plaque psoriasis at the start of treatment			
The patient has experienced a reduction compared to the pre-treatment baseline or	n of 75% or more in the skin area affected, or sustained at this level, as value			
O Patient has a Dermatology Quality of Life prior to commencing etanercept	fe Index (DLQI) improvement of 5 or more, as compared to baseline DLQI			
and _				
O Etanercept to be administered at doses no greater than 50	0 mg every 7 days			
INITIATION musdowns governous				
INITIATION – pyoderma gangrenosum  Prerequisites (tick boxes where appropriate)				
Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Patient has pyoderma gangrenosum*  Patient has received three months of conventional therapy including a minimum of three pharmaceuticals (e.g. prednisone, ciclosporing azathioprine, or methotrexate) and not received an adequate response				
			A maximum of 8 doses	
			Note: Indications marked with * are unapproved indications.	

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.

Name:  Name:  Name:  NHI:  Etanercept - continued  CONTINUATION - pyoderma gangrenosum Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  and  Patient has shown clinical improvement and A maximum of 8 doses  INITIATION - adult-onset Still's disease Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  and  The patient has had an initial Special Authority approval for etanercept for adult-onset Still's disease (AOSD)  The patient has been started on tocilizumab for AOSD in a Health NZ Hospital  and  The patient has received insufficient benefit from at least a three-month trial of adalimumab and/or tocilizumab such that they do not meet the renewal criteria for AOSD  Patient diagnosed with AOSD according to the Yamaguchi criteria (J Rheumatol 1992;19:424-430)  Patient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, non-steroidal antifilamatory drugs (NSAIDs) and methotrexate
Etanercept - continued  CONTINUATION - pyoderma gangrenosum Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  and  Patient continues to require treatment and A maximum of 8 doses  INITIATION - adult-onset Still's disease Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  and  The patient has had an initial Special Authority approval for etanercept for adult-onset Still's disease (AOSD)  or The patient has been started on tocilizumab for AOSD in a Health NZ Hospital  and  The patient has experienced intolerable side effects from etanercept and/or tocilizumab or The patient has received insufficient benefit from at least a three-month trial of adalimumab and/or tocilizumab such that they do not meet the renewal criteria for AOSD  Patient diagnosed with AOSD according to the Yamaguchi criteria (J Rheumatol 1992;19:424-430)  Patient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, non-steroidal
CONTINUATION – pyoderma gangrenosum Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Patient has shown clinical improvement and Patient continues to require treatment and A maximum of 8 doses  INITIATION – adult-onset Still's disease Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  The patient has had an initial Special Authority approval for etanercept for adult-onset Still's disease (AOSD)  The patient has been started on tocilizumab for AOSD in a Health NZ Hospital  and  The patient has experienced intolerable side effects from etanercept and/or tocilizumab and/or tocilizumab such that they do not meet the renewal criteria for AOSD  Patient diagnosed with AOSD according to the Yamaguchi criteria (J Rheumatol 1992;19:424-430)  Patient diagnosed with AOSD according to the Yamaguchi criteria (J Rheumatol 1992;19:424-430)  Patient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, non-steroidal
Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Patient has shown clinical improvement and Patient continues to require treatment and A maximum of 8 doses  INITIATION – adult-onset Still's disease Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  and  The patient has had an initial Special Authority approval for etanercept for adult-onset Still's disease (AOSD)  The patient has been started on tocilizumab for AOSD in a Health NZ Hospital and  The patient has experienced intolerable side effects from etanercept and/or tocilizumab or The patient has received insufficient benefit from at least a three-month trial of adalimumab and/or tocilizumab such that they do not meet the renewal criteria for AOSD  Patient diagnosed with AOSD according to the Yamaguchi criteria (J Rheumatol 1992;19:424-430)  Patient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, non-steroidal
Re-assessment required after 6 months  Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  The patient has had an initial Special Authority approval for etanercept for adult-onset Still's disease (AOSD)  The patient has been started on tocilizumab for AOSD in a Health NZ Hospital  and  The patient has experienced intolerable side effects from etanercept and/or tocilizumab or  The patient has received insufficient benefit from at least a three-month trial of adalimumab and/or tocilizumab such that they do not meet the renewal criteria for AOSD  Patient diagnosed with AOSD according to the Yamaguchi criteria (J Rheumatol 1992;19:424-430)  Patient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, non-steroidal
The patient has been started on tocilizumab for AOSD in a Health NZ Hospital  The patient has experienced intolerable side effects from etanercept and/or tocilizumab  The patient has received insufficient benefit from at least a three-month trial of adalimumab and/or tocilizumab such that they do not meet the renewal criteria for AOSD  Patient diagnosed with AOSD according to the Yamaguchi criteria (J Rheumatol 1992;19:424-430)  Patient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, non-steroidal
Patient diagnosed with AOSD according to the Yamaguchi criteria (J Rheumatol 1992;19:424-430)  Patient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, non-steroidal
and Patient has persistent symptoms of disabling poorly controlled and active disease
CONTINUATION – adult-onset Still's disease Re-assessment required after 6 months Prerequisites (tick box where appropriate)
Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  The patient has a sustained improvement in inflammatory markers and functional status

I confirm that the above details are correct:

SCRIB	ER		PATIENT:
e:			
d:			NHI:
nerce	pt -	conti	nued
TIATION assessi requisi	N - u mentites (	ribed tal.  Patie wrist,  Patie maxii  Patie dose	erentiated spondyloarthritis ired after 6 months oxes where appropriate)  by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ  int has undifferentiated peripheral spondyloarthritis* with active peripheral joint arthritis in at least four joints from the following: elbow, knee, ankle, and either shoulder or hip  int has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a mum tolerated dose  int has tried and not responded to at least three months of sulfasalazine at a dose of at least 2 g per day (or maximum tolerated
e: Indic	or		Patient has an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour measured no more than one month prior to the date of this application  ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months  arked with * are unapproved indications.
e. maic	Jalioi	15 1116	Thed with are unapproved indications.
assessi	ment	t requ	Indifferentiated spondyloarthritis ired after 6 months inoxes where appropriate)
0.1	or	O O	Applicant is a rheumatologist  Applicant is a Practitioner and confirms that a rheumatologist has provided a letter, email or fax recommending that the patient continues with etanercept treatment
and	or	O O	Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician  The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior etanercept treatment in the opinion of the treating physician
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I confirm that the above details are correct:

PRES	SCRIBER	PATIENT:
Name	x	Name:
Ward		NHI:
Beva	acizumab	
Re-a	ATION – Recurrent Respiratory Papillomatosis ssessment required after 12 months equisites (tick boxes where appropriate)	
and	Prescribed by, or recommended by an otolaryngologist, or in accord Hospital.	dance with a protocol or guideline that has been endorsed by the Health NZ
	Maximum of 6 doses  and The patient has recurrent respiratory papillomatosis and The treatment is for intra-lesional administration	
Re-a	ITINUATION – Recurrent Respiratory Papillomatosis ssessment required after 12 months equisites (tick boxes where appropriate)  Prescribed by, or recommended by an otolaryngologist, or in accord Hospital.	lance with a protocol or guideline that has been endorsed by the Health NZ
	O Maximum of 6 doses  and O The treatment is for intra-lesional administration and O There has been a reduction in surgical treatments or disease	regrowth as a result of treatment
	ATION – ocular conditions equisites (tick boxes where appropriate)	
	Ocular neovascularisation  Exudative ocular angiopathy	

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PRESCRIBER	PATIENT:
Name:	
Ward:	NHI:
Ranibizuma	b
Re-assessmen Prerequisites  Preso	Wet Age Related Macular Degeneration t required after 3 months (tick boxes where appropriate)  pribed by, or recommended by an ophthalmologist or nurse practitioner, or in accordance with a protocol or guideline that has been resed by the Health NZ Hospital.  O Wet age-related macular degeneration (wet AMD)  or O Polypoidal choroidal vasculopathy or
and	O The patient has developed severe endophthalmitis or severe posterior uveitis following treatment with bevacizumab O There is worsening of vision or failure of retina to dry despite three intraocular injections of bevacizumab four weeks apart
or	O There is no structural damage to the central fovea of the treated eye
Re-assessmen Prerequisites  Preso	ON – Wet Age Related Macular Degeneration t required after 12 months (tick boxes where appropriate)  cribed by, or recommended by an ophthalmologist or nurse practitioner, or in accordance with a protocol or guideline that has been resed by the Health NZ Hospital.  Documented benefit must be demonstrated to continue  Patient's vision is 6/36 or better on the Snellen visual acuity score  There is no structural damage to the central fovea of the treated eye

I confirm that the above details are correct:

#### RS2065 - Infliximab

Crohn's disease (adults) - INITIATION	324
Crohn's disease (adults) - CONTINUATION	324
Crohn's disease (children) - INITIATION	
Crohn's disease (children) - CONTINUATION	325
Graft vs host disease - INITIATION	320
Inflammatory bowel arthritis (axial) - INITIATION	330
Inflammatory bowel arthritis (axial) - CONTINUATION	330
Inflammatory bowel arthritis (peripheral) - INITIATION	331
Inflammatory bowel arthritis (peripheral) - CONTINUATION	331
Pulmonary sarcoidosis - INITIATION	
Acute fulminant ulcerative colitis - INITIATION	326
Ankylosing spondylitis - INITIATION	320
Ankylosing spondylitis - CONTINUATION	321
Chronic ocular inflammation - INITIATION	323
Chronic ocular inflammation - CONTINUATION	323
Fistulising Crohn's disease - INITIATION	325
Fistulising Crohn's disease - CONTINUATION	325
Fulminant ulcerative colitis - CONTINUATION	326
Neurosarcoidosis - INITIATION	328
Neurosarcoidosis - CONTINUATION	
Plaque psoriasis - INITIATION	327
Plaque psoriasis - CONTINUATION	328
Psoriatic arthritis - INITIATION	321
Psoriatic arthritis - CONTINUATION	321
Pyoderma gangrenosum - INITIATION	330
Pyoderma gangrenosum - CONTINUATION	330
Rheumatoid arthritis - INITIATION	
Rheumatoid arthritis - CONTINUATION	
Severe Behcet's disease - INITIATION	
Severe Behcet's disease - CONTINUATION	
Severe ocular inflammation - INITIATION	
Severe ocular inflammation - CONTINUATION	
Ulcerative colitis - INITIATION	
Ulcerative colitis - CONTINUATION	327

I confirm that the above details are correct:

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

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER					PATIENT:		
Name					Name:		
Ward:					NHI:		
Inflix	ima	ab					
				vs host disease			
Prere	`			box where appropriate) s steroid-refractory acute graft vs. host disease of the gu			
	<i></i>	Patie	nt nas	s steroid-refractory acute graft vs. nost disease of the gu			
				natoid arthritis uired after 4 months			
Prere	qui	sites	(tick b	boxes where appropriate)			
and	Hospital.				nce with a protocol or guideline that has been endorsed by the Health NZ		
	and	O	The	patient has had an initial Special Authority approval for a	dalimumab and/or etanercept for rheumatoid arthritis		
		or	0	The patient has experienced intolerable side effects from	om a reasonable trial of adalimumab and/or etanercept		
		or	0	Following at least a four month trial of adalimumab and adalimumab and/or etanercept	/or etanercept, the patient did not meet the renewal criteria for		
	and	O		tment is to be used as an adjunct to methotrexate theraperance	y or monotherapy where use of methotrexate is limited by toxicity or		
Prere	qui	sites	tick b	uired after 6 months boxes where appropriate) d by, or recommended by a rheumatologist, or in accorda	nce with a protocol or guideline that has been endorsed by the Health NZ		
and	and	C		tment is to be used as an adjunct to methotrexate theraperance	y or monotherapy where use of methotrexate is limited by toxicity or		
	unc	or	0	Following 3 to 4 months' initial treatment, the patient h clinically significant response to treatment in the opinio	as at least a 50% decrease in active joint count from baseline and a n of the physician		
			0	The patient demonstrates at least a continuing 30% im response to treatment in the opinion of the physician	provement in active joint count from baseline and a clinically significant		
	and	O	Inflix	kimab to be administered at doses no greater than 3 mg/k	kg every 8 weeks		
INITIATION – ankylosing spondylitis Re-assessment required after 3 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.							
	and		The	patient has had an initial Special Authority approval for a	dalimumab and/or etanercept for ankylosing spondylitis		
		or	0	The patient has experienced intolerable side effects from	om a reasonable trial of adalimumab and/or etanercept		
		J.	0	Following 12 weeks of adalimumab and/or etanercept and/or etanercept for ankylosing spondylitis	treatment, the patient did not meet the renewal criteria for adalimumab		
`							

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:				
Infliximab - continued					
CONTINUATION – ankylosing spondylitis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)					
Prescribed by, or recommended by a rheumatologist, or in accordar Hospital.	Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
Following 12 weeks of infliximab treatment, BASDAI has impror by 50%, whichever is less  and Physician considers that the patient has benefited from treatment	Following 12 weeks of infliximab treatment, BASDAI has improved by 4 or more points from pre-infliximab baseline on a 10 point scale, or by 50%, whichever is less  Physician considers that the patient has benefited from treatment and that continued treatment is appropriate  Infliximab to be administered at doses no greater than 5 mg/kg every 6-8 weeks				
INITIATION – psoriatic arthritis Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.					
The patient has experienced intolerable side effects fro	dalimumab and/or etanercept and/or secukinumab for psoriatic arthritis  m a reasonable trial of adalimumab and/or etanercept and/or secukinumab o and/or etanercept and/or secukinumab, the patient did not meet the or secukinumab for psoriatic arthritis.				
CONTINUATION – psoriatic arthritis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a rheumatologist, or in accordant Hospital.  and	nce with a protocol or guideline that has been endorsed by the Health NZ				
or clinically significant response to treatment in the opinion	provement in active joint count from baseline and a clinically significant				
O Infliximab to be administered at doses no greater than 5 mg/k	g every 8 weeks				

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.

PRES	CRIB	ER		PATIENT:	PATIENT:		
Name	e:			Name:	Name:		
Ward	:			NHI:			
nflix	ima	<b>b</b> - cc	ntinued	d			
Re-a	ssess	ment	equired a	cular inflammation d after 4 months es where appropriate)			
	(	and	) The	he patient has had an initial Special Authority approval for adalimumab for severe ocu	lar inflammation		
			or O	The patient has experienced intolerable side effects from adalimumab			
			$\Box$	The patient has received insufficient benefit from adalimumab to meet the renewa ocular inflammation	al criteria for adalimumab for severe		
	or	and	) Pati	atient has severe, vision-threatening ocular inflammation requiring rapid control			
			or O	Treatment with high-dose steroids (intravenous methylprednisolone) followed by hineffective at controlling symptoms  Patient developed new inflammatory symptoms while receiving high dose steroid  Patient is aged under 8 years and treatment with high dose oral steroids and other	s		
CON	TINU	ATION	– sever	ineffective at controlling symptoms ere ocular inflammation			
			-	d after 12 months es where appropriate)			
	or (	От	he patier	ient has had a good clinical response following 3 initial doses			
	or	١	Iomencla	ng each 12-month treatment period, the patient has had a sustained reduction in inflar clature (SUN) criteria $< \frac{1}{2}$ + anterior chamber or vitreous cells, absence of active vitreous tractive vitreous cells, absence of active vitreous macular oedema)			
	(			ng each 12-month treatment period, the patient has a sustained steroid sparing effect, daily, or steroid drops less than twice daily if under 18 years old	allowing reduction in prednisone to		
				should be considered after every 24 months of stability, unless the patient is deemed s withdrawn.	d to have extremely high risk of irreversible		

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.

PRES	SCRIE	BER		PATIENT:	PATIENT:		
Name	e:				Name:		
Ward	:			NHI:			
Inflix	kima	<b>b</b> - co	ontinue	ed			
Re-a	ssess	sment	requir	e ocular inflammation red after 4 months exes where appropriate)			
		and	<u>O</u> -	The patient has had an initial Special Authority approval for adalimumab for chronic ocular inflammation			
			or	O The patient has experienced intolerable side effects from adalimumab			
				O The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for chronic ocular inflammation			
	or	and		Patient has severe uveitis uncontrolled with treatment of steroids and other immunosuppressants with a severe risk of vision loss	n		
			or	O Patient is 18 years or older and treatment with at least two other immunomodulatory agents has proven ineffective O Patient is under 18 years and treatment with methotrexate has proven ineffective or is not tolerated at therapeutic dos			
			or	Patient is under 8 years and treatment with steroids or methotrexate has proven ineffective or is not tolerated at a therapeutic dose; or disease requires control to prevent irreversible vision loss prior to achieving a therapeutic dose of methotrexate.			
Re-a	ssess	sment	requir	pronic ocular inflammation red after 12 months roses where appropriate)			
	<b>0</b> *	0 -	The pa	atient has had a good clinical response following 3 initial doses			
	or (	1	Nomer	ring each 12-month treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis nclature (SUN) criteria $< \frac{1}{2}$ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of cystoid macular oedema)	:		
				ring each 12-month treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to g daily, or steroid drops less than twice daily if under 18 years old			
	Note: A trial withdrawal should be considered after every 24 months of stability, unless the patient is deemed to have extremely high risk of irreversible vision loss if infliximab is withdrawn.						
				nary sarcoidosis exes where appropriate)			
	and		Patien	t has life-threatening pulmonary sarcoidosis that is refractory to other treatments			
			Treatm	nent is to be prescribed by, or has been recommended by, a physician with expertise in the treatment of pulmonary sarcoido	osis		

I confirm that the above details are correct:

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

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER				PATIENT:		
Name: Name:						
Ward	:			NHI:		
Inflix	kima	ıb -	contin	ued		
Re-a	INITIATION – Crohn's disease (adults) Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)					
Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed NZ Hospital.  and						
	and	0	Patie	nt has active Crohn's disease		
		or	0	Patient has a CDAI score of greater than or equal to 300, or HBI score of greater than or equal to 10		
		or	0	Patient has extensive small intestine disease affecting more than 50 cm of the small intestine		
		or	0	Patient has evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel resection		
			$\cup$	Patient has an ileostomy or colostomy, and has intestinal inflammation		
	and	0		nt has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators corticosteroids		
	equis	Preso NZ H or or	(tick beribed ospital)  O  Inflixiup to	by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health II.  CDAI score has reduced by 100 points from the CDAI score, or HBI score has reduced by 3 points, from when the patient was initiated on infliximab  CDAI score is 150 or less, or HBI is 4 or less  The patient has demonstrated an adequate response to treatment but CDAI score and/or HBI score cannot be assessed  mab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for 3 doses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen s after completing the last re-induction cycle		
INITIATION – Crohn's disease (children) Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)						
and			ribed ospita	by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health II.		
	and	O	Paed	iatric patient has active Crohn's disease		
		or	O O	Patient has a PCDAI score of greater than or equal to 30  Patient has extensive small intestine disease		
	and	0		nt has tried but experienced an inadequate response to, or intolerable side effects from, prior therapy with immunomodulators corticosteroids		

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.

PRES	CRII	BER		PATIENT:
Name:				
Ward:				NHI:
Inflix	ima	ıb -	contir	nued
Re-as	ssess equis	smer sites Pres NZ F or or	trequitive (tick I	Crohn's disease (children) uired after 2 years boxes where appropriate)  d by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health al.  PCDAI score has reduced by 10 points from the PCDAI score when the patient was initiated on infliximab  PCDAI score is 15 or less  The patient has demonstrated an adequate response to treatment but PCDAI score cannot be assessed  kimab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for a 3 doses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen
Prere	sses: quis	smer sites	istuli t requ (tick l	ising Crohn's disease uired after 6 months boxes where appropriate)  d by, or recommended by a gastroenterologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and	and	O or or	Patie	Patient has one or more complex externally draining enterocutaneous fistula(e)  Patient has one or more rectovaginal fistula(e)  Patient has complete peri-anal fistula
Re-as	ssess equis	smer sites Presi NZ F	t required (tick I	The number of open draining fistulae have decreased from baseline by at least 50%  There has been a marked reduction in drainage of all fistula(e) from baseline (in the case of adult patients, as demonstrated by a reduction in the Fistula Assessment score), together with less induration and patient reported pain
			up to	kimab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for o 3 doses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen ks after completing the last re-induction cycle

	stocol or guideline that has been endorsed by the Health NZ
Infliximab - continued  INITIATION – acute fulminant ulcerative colitis Re-assessment required after 6 weeks	
INITIATION – acute fulminant ulcerative colitis Re-assessment required after 6 weeks	stocol or guideline that has been endorsed by the Health NZ
Re-assessment required after 6 weeks	stocol or guideline that has been endorsed by the Health NZ
Prescribed by, or recommended by a gastroenterologist, or in accordance with a pro Hospital.	
Patient has acute, fulminant ulcerative colitis and Treatment with intravenous or high dose oral corticosteroids has not been suc	cessful
CONTINUATION – fulminant ulcerative colitis Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by any relevant practitioner, or in accordance with a NZ Hospital.	a protocol or guideline that has been endorsed by the Health
Where maintenance treatment is considered appropriate, infliximab should be reassessed every 6 months  and  Infliximab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 up to 3 doses if required for secondary non-response to treatment for re-inductive weeks after completing the last re-induction cycle	mg/kg every 8 weeks (or equivalent) can be used for
INITIATION – ulcerative colitis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  Or Prescribed by, or recommended by any relevant practitioner, or in accordance with a NZ Hospital.  and  Or Patient has active ulcerative colitis	a protocol or guideline that has been endorsed by the Health
Patient has active dicerative collis  Or Patients SCCAI is greater than or equal to 4  Or Patients PUCAI score is greater than or equal to 20  and Patient has experienced an inadequate response to, or intolerable side effects systemic corticosteroids	s from, prior therapy with immunomodulators and

I confirm that the above details are correct:	
Signed:	Date:

I confirm that the above details are correct:

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

#### HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRES	CRII	BER			PATIENT:
Name	):				
Ward	:				NHI:
Inflix	ima	<b>ab</b> - d	contin	ued	
Re-a	sses	smen	t requ	ired at	vive colitis fiter 2 years where appropriate)
and			ribed ospita		recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
		or	0		SCCAI score has reduced by 2 points or more from the SCCAI score when the patient was initiated on infliximab
				The I	PUCAI score has reduced by 30 points or more from the PUCAI score when the patient was initiated on infliximab
	and	0	up to	3 dos	be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for set if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen completing the last re-induction cycle
Re-a	sses equi:	smen sites	t requ (tick b cribed	oxes \	riasis iter 3 doses where appropriate) recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
		and		Patie	nt has had an initial Special Authority approval for adalimumab, etanercept or secukinumab for severe chronic plaque asis
			or	0	Patient has experienced intolerable side effects from adalimumab, etanercept or secukinumab  Patient has received insufficient benefit from adalimumab, etanercept or secukinumab to meet the renewal criteria for adalimumab, etanercept or secukinumab for severe chronic plaque psoriasis
	or				
			or	<ul><li>O</li><li>O</li><li>O</li></ul>	Patient has "whole body" severe chronic plaque psoriasis with a Psoriasis Area and Severity Index (PASI) score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis  Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis  Patient has severe chronic localised genital or flexural plaque psoriasis where the plaques or lesions have been present for at least 6 months from the time of initial diagnosis, and with a Dermatology Life Quality Index (DLQI) score greater than 10
		and		A PA	In thas tried, but had an inadequate response (see Note) to, or has experienced intolerable side effects from, at least three e following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, cyclosporin, or acitretin SI assessment has been completed for at least the most recent prior treatment course (but preferably all prior treatment ses), preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course most recent PASI assessment is no more than 1 month old at the time of initiation
while face, seve	still hand re, ar	on tre d, foo nd for	atme t, gen the fa	nt but ital or ace, pa	se" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 10, as assessed preferably no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the flexural areas at least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very alm of a hand or sole of a foot the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed atment but no longer than 1 month following cessation of the most recent prior treatment.

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:
Infliximab - continued	
CONTINUATION – plaque psoriasis Re-assessment required after 3 doses Prerequisites (tick boxes where appropriate)	
or  Patient had severe chronic plaque psoriasis of the and  Following each prior infliximab treatment co for all 3 of erythema, thickness and scaling treatment course baseline values  Following each prior infliximab treatment course baseline values  Following each prior infliximab treatment course baseline values	he patient has a PASI score which is reduced by 75% or more, or is
Or Patient had severe chronic localised genital or flee and O The patient has experienced a reduction of compared to the pre-treatment baseline value.	xural plaque psoriasis at the start of treatment  75% or more in the skin area affected, or sustained at this level, as ue  Index (DLQI) improvement of 5 or more, as compared to baseline DLQI
Hospital.	with a protocol or guideline that has been endorsed by the Health NZ
Biopsy consistent with diagnosis of neurosarcoidosis and Patient has CNS involvement and Patient has steroid-refractory disease and  IV cyclophosphamide has been tried  Treatment with IV cyclophosphamide is clinically inappr	opriate

I confirm that the above details are correct:

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Signeg.	 Date:	
Cigilou.	 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:
Infliximab - continued	
CONTINUATION – neurosarcoidosis Re-assessment required after 18 months Prerequisites (tick boxes where appropriate)	t be clinically appropriate
or  The patient has severe gastrointestinal, rheumatologic two or more treatment appropriate for the particular symptom(s) (	culitic symptoms and has not responded adequately to one or more see Notes) and/or mucocutaneous symptoms and has not responded adequately to
The patient is experiencing significant loss of quality of life	
<ul> <li>Note:</li> <li>a) Behcet's disease diagnosed according to the International Study Group for measured using an appropriate quality of life scale such as that published</li> <li>b) Treatments appropriate for the particular symptoms are those that are con intravenous/oral steroids and other immunosuppressants for ocular symptoms; and colchicine, steroids and methotrexate for</li> </ul>	in Gilworth et al J Rheumatol. 2004;31:931-7.  sidered standard conventional treatments for these symptoms, for example oms; azathioprine, steroids, thalidomide, interferon alpha and ciclosporin for
CONTINUATION – severe Behcet's disease Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  Patient has had a good clinical response to initial treatment wand Infliximab to be administered at doses no greater than 5 mg/kg	

I confirm that the above details are correct:

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

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Infliximab - continued		
INITIATION – pyoderma gangrenosum  Prerequisites (tick boxes where appropriate)		
Hospital.	e with a protocol or guideline that has been endorsed by the Health NZ	
Patient has pyoderma gangrenosum*  Patient has received three months of conventional therapy incl azathioprine, or methotrexate) and not received an adequate read A maximum of 8 doses	uding a minimum of three pharmaceuticals (e.g. prednisone, ciclosporin, esponse	
Note: Indications marked with * are unapproved indications.		
CONTINUATION – pyoderma gangrenosum  Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a dermatologist, or in accordance Hospital.	e with a protocol or guideline that has been endorsed by the Health NZ	
Patient has shown clinical improvement and Patient continues to require treatment and A maximum of 8 doses		
INITIATION – Inflammatory bowel arthritis (axial) Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)		
by a physiotherapist  And  Patient has a BASDAI of at least 6 on a 0-10 scale completed pharmacological treatment  CONTINUATION – Inflammatory bowel arthritis (axial)  Re-assessment required after 2 years		
Prerequisites (tick box where appropriate)  O Where treatment has resulted in an improvement in BASDAI of 4 or improvement in BASDAI of 50%, whichever is less	more points from pre-treatment baseline on a 10-point scale, or an	

Page 331

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.

PRES	CRIE	BER		PATIENT:			
Name:				Name:			
Ward:				NHI:			
Inflix	ima	b -	continued				
Re-as	ses	smen	nflammatory bowel arthritis (peripheral) t required after 6 months (tick boxes where appropriate)				
	and	O	Patient has a diagnosis of active ulcerative colitis or active Cro	phn's disease			
	and	0	Patient has active arthritis in at least four joints from the follow sternoclavicular	ing: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder,			
	and	0	Patient has tried and not experienced a response to at least th dose (unless contraindicated)	ree months of methotrexate or azathioprine at a maximum tolerated			
		0	Patient has tried and not experienced a response to at least three months of sulfasalazine at a maximum tolerated dose (unless contraindicated)				
	and	or	O Patient has a CRP level greater than 15 mg/L measured	I no more than one month prior to the date of this application			
			O Patient has an ESR greater than 25 mm per hour measurements	ured no more than one month prior to the date of this application			
		or	O ESR and CRP not measured as patient is currently received has done so for more than three months	iving prednisone therapy at a dose of greater than 5 mg per day and			
Re-as	ses	smen	N – Inflammatory bowel arthritis (peripheral) t required after 2 years (tick boxes where appropriate)				
	or	0	Following initial treatment, patient has experienced at least a significant response to treatment in the opinion of the physicia	50% decrease in active joint count from baseline and a clinically n			
	or	0	Patient has experienced at least a continuing 30% improveme physician	nt in active joint count from baseline in the opinion of the treating			

I confirm that the above details are correct:

#### RS2067 - Tocilizumab

П		
l	Rheumatoid Arthritis - INITIATION	335
l	Rheumatoid Arthritis - CONTINUATION	337
l	Rheumatoid Arthritis (patients previously treated with adalimumab or etanercept) - INITIATION	334
l	Adult-onset Still's disease - INITIATION	
l	Adult-onset Still's disease - CONTINUATION	338
l	Cytokine release syndrome - INITIATION	333
l	Idiopathic multicentric Castleman's disease - INITIATION	
l	Idiopathic multicentric Castleman's disease - CONTINUATION	338
l	Moderate to severe COVID-19 - INITIATION	337
l	Polyarticular juvenile idiopathic arthritis - INITIATION	336
l	Polyarticular juvenile idiopathic arthritis - CONTINUATION	
l	Previous use - INITIATION	333
l	Systemic juvenile idiopathic arthritis - INITIATION	335
l	Systemic juvenile idiopathic arthritis - CONTINUATION	
1		

	PATIENT:
	Name:
	NHI:
tokine release syndrome required after 3 doses ck boxes where appropriate)  The patient has developed grade 3 or 4 cytokine release treatment of acute lymphoblastic leukaemia  Tocilizumab is to be administered at doses no greater that of 12 mg/kg)  The patient is enrolled in the Malaghan Institute of Medic  The patient has developed CRS or Immune Effector Cell- therapy for the treatment of relapsed or refractory B-cell relationships of the conse greater than 8 mg/kg IV for a maximum of 3 doses  revious use required after 6 months ck boxes where appropriate)	syndrome associated with the administration of blinatumomab for the an 8 mg/kg IV for a maximum of 3 doses (if less than 30kg, maximum al Research ENABLE trial programme Associated Neurotoxicity Syndrome (ICANS) following CAR T-Cell non-Hodgkin lymphoma Insus guidelines for CRS or ICANS for CAR T-cell therapy at doses no
O Systemic juvenile idiopathic arthritis	
Adult-onset Still's disease	
O Polyarticular juvenile idiopathic arthritis	
, , , , , , , , , , , , , , , , , , , ,	
tre combined to the combined t	Okine release syndrome equired after 3 doses ck boxes where appropriate)  The patient has developed grade 3 or 4 cytokine release treatment of acute lymphoblastic leukaemia  Tocilizumab is to be administered at doses no greater that of 12 mg/kg)  The patient has developed CRS or Immune Effector Cell- therapy for the treatment of relapsed or refractory B-cell related than 8 mg/kg IV for a maximum of 3 doses  Prious use equired after 6 months ck boxes where appropriate)  Ded by, or recommended by any relevant practitioner, or in accepital.  Atlient was being treated with tocilizumab prior to 1 February 2  Rheumatoid arthritis  Systemic juvenile idiopathic arthritis  Adult-onset Still's disease

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER	P	ATIENT:
Name:	N	lame:
Ward:	N	IHI:
Tocilizumab - co	ontinued	
	umatoid Arthritis (patients previously treated with adalim	umab or etanercept)
	boxes where appropriate)	
	d by, or recommended by a rheumatologist or Practitioner on or guideline that has been endorsed by the Health NZ Hospita	the recommendation of a rheumatologist, or in accordance with a al.
	e patient has had an initial Special Authority approval for adali	imumab and/or etanercept for rheumatoid arthritis
	The patient has experienced intolerable side effects from a	adalimumab and/or etanercept
or	The patient has received insufficient benefit from at least a not meet the renewal criteria for rheumatoid arthritis	three-month trial of adalimumab and/or etanercept such that they do
and	The patient is seronegative for both anti-cyclic citrullinated	pentide (CCP) antibodies and rheumatoid factor
or	The patient is seronegative for both anti-cyclic citrumnated	peptide (OOT) antibodies and medinatoid factor
a	<ul> <li>The patient has been started on rituximab for rheum.</li> </ul>	atoid arthritis in a Health NZ Hospital
	The patient has experienced intolerable side e  O  At four months following the initial course of rit do not meet the renewal criteria for rheumatoic	uximab the patient has received insufficient benefit such that they

C:	D-1	
Signed.	Date:	
Oigilica.	 Daic.	

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:			PATIENT:		
Name	lame:			Name:	
Ward:	Vard:NHI:				
Tocil	izun	nab	- cor	ntinued	
Re-a	ssess equis	men ites	t requ (tick b	matoid Arthritis ired after 6 months oxes where appropriate) by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a	
and				guideline that has been endorsed by the Health NZ Hospital.	
	and	С		nt has had severe and active erosive rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic linated peptide (CCP) antibody positive) for six months duration or longer	
	and	C	Tocili	zumab is to be used as monotherapy	
		or	0	Treatment with methotrexate is contraindicated	
			$\cup$	Patient has tried and did not tolerate oral and/or parenteral methotrexate	
	and	or	0	Patient has tried and not responded to at least three months therapy at the maximum tolerated dose of ciclosporin alone or in combination with another agent	
		OI .	0	Patient has tried and not responded to at least three months therapy at the maximum tolerated dose of leflunomide alone or in combination with another agent	
	and	or	0	Patient has persistent symptoms of poorly controlled and active disease in at least 20 active, swollen, tender joints	
			0	Patient has persistent symptoms of poorly controlled and active disease in at least four active joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip	
	and	or	0	Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application	
		OI .	0	C-reactive protein levels not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months	
Re-a	ssess equis	men ites	t requ (tick b	mic juvenile idiopathic arthritis ired after 6 months boxes where appropriate)  by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a	
and	p	roto		guideline that has been endorsed by the Health NZ Hospital.	
	and	$\mathcal{I}$		nt diagnosed with systemic juvenile idiopathic arthritis	
		<u>ر</u>		nt has tried and not responded to a reasonable trial of all of the following, either alone or in combination: oral or parenteral otrexate; non-steroidal anti-inflammatory drugs (NSAIDs); and systemic corticosteroids	

I confirm that the above details are correct:

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

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Name:	BER		PATIENT:
Nard:			NHI:
Tocilizu	mab -	- contin	ued
Re-asses	ssment i <b>sites</b> (t	require ick box ibed by	set Still's disease d after 6 months es where appropriate) , or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a ideline that has been endorsed by the Health NZ Hospital.
	and	or (	The patient has had an initial Special Authority approval for adalimumab and/or etanercept for adult-onset Still's disease (AOSD)  The patient has been started on tocilizumab for AOSD in a Health NZ Hospital  The patient has experienced intolerable side effects from adalimumab and/or etanercept  The patient has received insufficient benefit from at least a three-month trial of adalimumab and/or etanercept such that
or			The patient has received insufficient benefit from at least a three-month trial of adalimumab and/or etanercept such that they do not meet the renewal criteria for AOSD
	and	O P	atient diagnosed with AOSD according to the Yamaguchi criteria (J Rheumatol 1992;19:424-430)  atient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, non-steroidal ntiinflammatory drugs (NSAIDs) and methotrexate  atient has persistent symptoms of disabling poorly controlled and active disease
Re-asses Prerequi	ssment isites (t	require ick box ibed by	cular juvenile idiopathic arthritis d after 4 months es where appropriate) , or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a ideline that has been endorsed by the Health NZ Hospital.
Re-asses	ssment isites (t	require requir	d after 4 months es where appropriate) , or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a
Re-asses Prerequi	Prescri	require requir	d after 4 months es where appropriate) , or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a ideline that has been endorsed by the Health NZ Hospital.  The patient has had an initial Special Authority approval for both etanercept and adalimumab for polyarticular course juvenile iopathic arthritis (JIA)

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.

PRES	SCRI	BER	F	PATIENT:
Name	e:		n	Name:
Ward	ard:NHI:			
Toci	lizu	mab	- continued	
INIT Re-a	IATIC sses equi	Preso or in a	diopathic multicentric Castleman's disease it required after 6 months (tick boxes where appropriate)	eman's disease
		$\bigcirc$	Tocilizumab to be administered at doses no greater than 8 mg/kg	g IV every 3-4 weeks
Re-a	sses	sites	moderate to severe COVID-19 It required after 1 dose (tick boxes where appropriate)  Patient has confirmed (or probable) COVID-19  Oxygen saturation of < 92% on room air, or requiring supplement Patient is receiving adjunct systemic corticosteroids, or systemic Tocilizumab is to be administered at doses no greater than 8mg/	corticosteroids are contraindicated  (kg IV for a maximum of one dose
Re-a	sses equi	smen sites Presc	ON – Rheumatoid Arthritis It required after 6 months (tick boxes where appropriate) cribed by, or recommended by a rheumatologist or Practitioner or col or guideline that has been endorsed by the Health NZ Hospita	the recommendation of a rheumatologist, or in accordance with a
and	or	O O	Following 6 months' initial treatment, the patient has at least a 5 significant response to treatment in the opinion of the physician On subsequent reapplications, the patient demonstrates at least a clinically significant response to treatment in the opinion of the	a continuing 30% improvement in active joint count from baseline and
Re-a	sses equi	smen sites Preso	col or guideline that has been endorsed by the Health NZ Hospita	ved at least an American College of Rheumatology paediatric 30%

PRESC	RIBER			PATIENT:
Name:				Name:
Ward:				NHI:
Tociliz	zumab	- con	ntinued	
Re-ass	sessmen  uisites   Preso	t requ (tick b cribed	dult-onset Still's disease ired after 6 months ox where appropriate) by, or recommended by a rheumatologist or Practitioner of guideline that has been endorsed by the Health NZ Hospi	on the recommendation of a rheumatologist, or in accordance with a
and			has a sustained improvement in inflammatory markers at	
Re-ass	sessmen juisites Preso	t requ (tick b cribed	olyarticular juvenile idiopathic arthritis ired after 6 months oxes where appropriate)  by, or recommended by a rheumatologist or Practitioner of guideline that has been endorsed by the Health NZ Hosp	on the recommendation of a rheumatologist, or in accordance with a tal.
í	O and		ment is to be used as an adjunct to methotrexate therapy rance	or monotherapy where use of methotrexate is limited by toxicity or
	or	0	Following 3 to 4 months' initial treatment, the patient has physician's global assessment from baseline	at least a 50% decrease in active joint count and an improvement in
		0	On subsequent reapplications, the patient demonstrates continued improvement in physician's global assessment	at least a continuing 30% improvement in active joint count and from baseline
Re-ass	essmen uisites Preso or in	t requ (tick b cribed accord	dance with a protocol or guideline that has been endorsed	or Practitioner on the recommendation of a haematologist or rheumatologist, by the Health NZ Hospital.  Inprovement in inflammatory markers and functional status

I confirm that the above details are correct:

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PRESCRIBER		PATIENT:
Name:		Name:
Ward:		NHI:
Omalizumab		
INITIATION – s Re-assessmen Prerequisites  Presc	severe asthma t required after 6 months (tick boxes where appropriate) cribed by, or recommended by a clinical immunologist or respirarsed by the Health NZ Hospital.  Patient must be aged 6 years or older Patient has a diagnosis of severe asthma  Past or current evidence of atopy, documented by skin prick te Total serum human immunoglobulin E (IgE) between 76 IU/mII Proven adherence with optimal inhaled therapy including high	dose inhaled corticosteroid (budesonide 1,600 mcg per day or long-acting beta-2 agonist therapy (at least salmeterol 50 mcg bd or
and O and	Contraindicated or not tolerated  Patient has had at least 4 exacerbations needing system defined as either documented use of oral corticosteroids  Patient has an Asthma Control Test (ACT) score of 10 or less	the ACT and oral corticosteroid dose must be made at the time of
Re-assessmen Prerequisites  Presc	ON – severe asthma t required after 6 months (tick boxes where appropriate) cribed by, or recommended by a respiratory specialist, or in accospital.  An increase in the Asthma Control Test (ACT) score of at leas A reduction in the maintenance oral corticosteroid dose or nur	

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.

PRESCRIB	ER	PATIENT:
Name:		. Name:
Ward:		. NHI:
Omalizun	nab - continued	
Re-assessr Prerequisi	N – severe chronic spontaneous urticaria ment required after 6 months ites (tick boxes where appropriate) Prescribed by, or recommended by a clinical immunologist or derrendorsed by the Health NZ Hospital.	natologist, or in accordance with a protocol or guideline that has been
and	Patient must be aged 12 years or older	
	Patient is symptomatic with Urticaria Activity Scand Patient has a Dermatology life quality index (DL	
and		
	O Patient has been taking high dose antihistamines (e.g or	. 4 times standard dose) and ciclosporin (> 3 mg/kg day) for at least
	Patient has been taking high dose antihistamines (e.g (> 20 mg prednisone per day for at least 5 days) in the	. 4 times standard dose) and at least 3 courses of systemic corticosteroids e previous 6 months
	O Patient has developed significant adverse effects while	st on corticosteroids or ciclosporin
and	O Treatment to be stopped if inadequate response* follo	wing 4 doses
	O Complete response* to 6 doses of omalizumab	
CONTINUA	ATION – severe chronic spontaneous urticaria	
	ment required after 6 months  ites (tick boxes where appropriate)	
	Prescribed by, or recommended by a clinical immunologist or derrendorsed by the Health NZ Hospital.	natologist, or in accordance with a protocol or guideline that has been
or	Patient has previously had a complete response* to 6 doses	s of omalizumab
	O Patient has previously had a complete response* to 6	doses of omalizumab
	O Patient has relapsed after cessation of omalizumab th	nerapy
of less than	n 4 from baseline. Patient is to be reassessed for response after and DLQI less than or equal to 5; or UCT of 16. Relapse of chro	e UAS7 and DLQI score, or an increase in Urticaria Control Test (UCT) score 4 doses of omalizumab. Complete response is defined as UAS7 less than or nic urticaria on stopping prednisone/ciclosporin does not justify the funding of

I confirm that the above details are correct:

PRESC	RIBER	PATIENT:
Name:		Name:
Ward: .		NHI:
Siltuxi	imab	
Prereq and a	essment required after 6 months uisites (tick boxes where appropriate)	ineffective
Re-ass	NUATION essment required after 12 months uisites (tick box where appropriate)  Prescribed by, or recommended by a haematologist or rheumatologist the Health NZ Hospital.  The treatment remains appropriate and the patient has sustained im	ist, or in accordance with a protocol or guideline that has been endorsed by aprovement in inflammatory markers and functional status

I confirm that the above details are correct:

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I confirm that the above details are correct:

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

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

RESCRIBER	PATIENT:
ıme:	
ard:	NHI:
inutuzum	ab
ITIATION e-assessmer	t required after 6 months
rerequisites	(tick boxes where appropriate)
O Preso	cribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.
O	The patient has progressive Binet stage A, B or C CD20+ chronic lymphocytic leukaemia requiring treatment
and	The patient is obinutuzumab treatment naive
0	The patient is not eligible for full dose FCR due to comorbidities with a score > 6 on the Cumulative Illness Rating Scale (CIRS) or reduced renal function (creatinine clearance < 70mL/min)
and	Patient has adequate neutrophil and platelet counts* unless the cytopenias are a consequence of marrow infiltration by CLL
and	Patient has good performance status
0	Obinutuzumab to be administered at a maximum cumulative dose of 8,000 mg and in combination with chlorambucil for a maximum of 6 cycles
	lymphocytic leukaemia includes small lymphocytic lymphoma. Comorbidity refers only to illness/impairment other than CLL induced ent in the patient. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL diseas
ness/impairm mptoms a hi greater than o	ent in the patient. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL diseas gher ECOG (2 or 3) is acceptable where treatment with obinutuzumab is expected to improve symptoms and improve ECOG score to < 2 or equal to 1.5 × 10 <sup>9</sup> /L and platelets greater than or equal to 75 × 10 <sup>9</sup> /L
ness/impairm mptoms a hi greater than o ITIATION – f e-assessmer	ent in the patient. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL diseas gher ECOG (2 or 3) is acceptable where treatment with obinutuzumab is expected to improve symptoms and improve ECOG score to < 2
ess/impairm mptoms a hi reater than o ITIATION – 1 e-assessmen erequisites	ent in the patient. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL diseas gher ECOG (2 or 3) is acceptable where treatment with obinutuzumab is expected to improve symptoms and improve ECOG score to < 2 or equal to 1.5 × 10 <sup>9</sup> /L and platelets greater than or equal to 75 × 10 <sup>9</sup> /L  follicular / marginal zone lymphoma It required after 9 months
ness/impairm mptoms a hi preater than of itiation – for e-assessmer	ent in the patient. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL diseas gher ECOG (2 or 3) is acceptable where treatment with obinutuzumab is expected to improve symptoms and improve ECOG score to < 2 or equal to 1.5 × 10 <sup>9</sup> /L and platelets greater than or equal to 75 × 10 <sup>9</sup> /L  follicular / marginal zone lymphoma It required after 9 months  (tick boxes where appropriate)
ess/impairm mptoms a hi preater than of arrangement of the company	ent in the patient. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL disease gher ECOG (2 or 3) is acceptable where treatment with obinutuzumab is expected to improve symptoms and improve ECOG score to < 2 or equal to 1.5 × 10 <sup>9</sup> /L and platelets greater than or equal to 75 × 10 <sup>9</sup> /L  **Collicular / marginal zone lymphoma** (tick boxes where appropriate)  **OPERIOR OF THE PROPRIES OF
ess/impairm mptoms a hi reater than o  ITIATION – 1assessmer erequisites  or  and  and	ent in the patient. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL diseas gher ECOG (2 or 3) is acceptable where treatment with obinutuzumab is expected to improve symptoms and improve ECOG score to < 2 or equal to 1.5 × 10 <sup>9</sup> /L and platelets greater than or equal to 75 × 10 <sup>9</sup> /L  **Collicular / marginal zone lymphoma** It required after 9 months  (tick boxes where appropriate)   **O Patient has follicular lymphoma**  Patient has marginal zone lymphoma**
ess/impairm mptoms a hi preater than of arrangements arra	ent in the patient. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL diseas gher ECOG (2 or 3) is acceptable where treatment with obinutuzumab is expected to improve symptoms and improve ECOG score to < 2 or equal to 1.5 × 10 <sup>9</sup> /L and platelets greater than or equal to 75 × 10 <sup>9</sup> /L  **Collicular / marginal zone lymphoma** It required after 9 months  (tick boxes where appropriate)   **O Patient has follicular lymphoma**  Patient has marginal zone lymphoma  Patient is refractory to or has relapsed within 12 months of a rituximab containing combined chemo-immunotherapy regimen**
ess/impairm mptoms a hi preater than of arrangements arra	ent in the patient. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL disease gher ECOG (2 or 3) is acceptable where treatment with obinutuzumab is expected to improve symptoms and improve ECOG score to < 2 or equal to 1.5 × 10 <sup>9</sup> /L and platelets greater than or equal to 75 × 10 <sup>9</sup> /L  **Tollicular / marginal zone lymphoma** It required after 9 months (tick boxes where appropriate)  **Patient has follicular lymphoma**  Patient has marginal zone lymphoma  Patient is refractory to or has relapsed within 12 months of a rituximab containing combined chemo-immunotherapy regimen**  Patient has an ECOG performance status of 0-2
ess/impairm mptoms a hi greater than o  ITIATION – f e-assessmer rerequisites  or  and and and and and and	ent in the patient. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL diseas gher ECOG (2 or 3) is acceptable where treatment with obinutuzumab is expected to improve symptoms and improve ECOG score to < 2 or equal to 1.5 × 10 <sup>9</sup> /L and platelets greater than or equal to 75 × 10 <sup>9</sup> /L  **Collicular / marginal zone lymphoma** It required after 9 months (tick boxes where appropriate)  **Patient has follicular lymphoma**  Patient has marginal zone lymphoma  Patient is refractory to or has relapsed within 12 months of a rituximab containing combined chemo-immunotherapy regimen**  Patient has an ECOG performance status of 0-2  Patient has been previously treated with no more than four chemotherapy regimens
ness/impairm mptoms a hi greater than of itriation — for-assessmer rerequisites  or and and and or and or and or or and or or and or	ent in the patient. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL diseas gher ECOG (2 or 3) is acceptable where treatment with obinutuzumab is expected to improve symptoms and improve ECOG score to < 2 or equal to 1.5 × 10 <sup>9</sup> /L and platelets greater than or equal to 75 × 10 <sup>9</sup> /L  **Collicular / marginal zone lymphoma** It required after 9 months (tick boxes where appropriate)  **Patient has follicular lymphoma**  Patient has marginal zone lymphoma  Patient is refractory to or has relapsed within 12 months of a rituximab containing combined chemo-immunotherapy regimen*  Patient has an ECOG performance status of 0-2  Patient has been previously treated with no more than four chemotherapy regimens  Obinutuzumab to be administered at a maximum dose of 1000 mg for a maximum of 6 cycles in combination with chemotherapy*
ness/impairm mptoms a hi greater than of itriation — for-assessmer rerequisites  or and and and or and or and or or and or or and or	ent in the patient. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL diseas gher ECOG (2 or 3) is acceptable where treatment with obinutuzumab is expected to improve symptoms and improve ECOG score to < 2 or equal to 1.5 × 10 <sup>9</sup> /L and platelets greater than or equal to 75 × 10 <sup>9</sup> /L    Collicular / marginal zone lymphoma
ness/impairm Imptoms a hi Igreater than of Interpretation of the content of the c	ent in the patient. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL diseas gher ECOG (2 or 3) is acceptable where treatment with obinutuzumab is expected to improve symptoms and improve ECOG score to < 2 or equal to 1.5 × 10°/L and platelets greater than or equal to 75 × 10°/L    Collicular / marginal zone lymphoma

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pertuzumab	
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
The patient has metastatic breast cancer expressing HER-2 and	IHC 3+ or ISH+ (including FISH or other current technology)
O Patient is chemotherapy treatment naive	
Patient has not received prior treatment for their metas between prior (neo)adjuvant chemotherapy treatment a	tatic disease and has had a treatment free interval of at least 12 months and diagnosis of metastatic breast cancer
The patient has good performance status (ECOG grade 0-1)  and Pertuzumab to be administered in combination with trastuzur  and Pertuzumab maximum first dose of 840 mg, followed by max  and Pertuzumab to be discontinued at disease progression	mab
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
The cancer has not progressed at any time point during	ER-2 IHC 3+ or ISH+ (including FISH or other current technology) g the previous 12 months whilst on pertuzumab and trastuzumab
Patient has previously discontinued treatment with periodisease progression  and Patient has signs of disease progression and Disease has not progressed during previous treatment	tuzumab and trastuzumab for reasons other than severe toxicity or
2 2.0000 max max programming provided thoutinome	

	community funding, see the Special Authority Criteria.	
PRESCRIBER		PATIENT:
Name:		Name:
Ward:		NHI:
Cetuximab		
	head and neck cancer, locally advanced (tick boxes where appropriate)	
and	Patient has locally advanced, non-metastatic, squamous cell of Cisplatin is contraindicated or has resulted in intolerable side	
and and	Patient has an ECOG performance score of 0-2  To be administered in combination with radiation therapy	
	To be administred in combination with radiation therapy	
Re-assessment Prerequisites  and and and and or	O Chemotherapy is determined to not be in the best interest	b apy
Prerequisites  No e	ON – colorectal cancer, metastatic nt required after 6 months (tick box where appropriate) vidence of disease progression ed colorectal cancer comprises of the distal one-third of the tran	nsverse colon, the splenic flexure, the descending colon, the sigmoid colon,

I confirm that the above details are correct:

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Signed.	Date:	
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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.

Name:
NHI:
tioner, or in accordance with a protocol or guideline that has been
r than wet AMD
or severe posterior uveitis following treatment with bevacizumab  y despite three intraocular injections of bevacizumab four weeks  reated eye  for longer than 3 months
ment of wAMD and was found to be intolerant to ranibizumab within ment with ranibizumab for wAMD and disease was stable while on
tioner, or in accordance with a protocol or guideline that has been re eye
t t

PRESCRIBER		PATIENT:		
Name: Name:				
Ward:	Ward:NHI:			
Aflibercept -	continued			
Re-assessment Prerequisites (t	iabetic Macular Oedema required after 4 months tick boxes where appropriate) ibed by, or recommended by an ophthalmologist or nurse praced by the Health NZ Hospital.	ctitioner, or in accordance with a protocol or guideline that has been		
and Fand Fand Fand Fand	Patient has centre involving diabetic macular oedema (DMO)  Patient's disease is non responsive to 4 doses of intravitreal be patient has reduced visual acuity between 6/9 – 6/36 with function patient has DMO within central OCT (ocular coherence tomogon There is no centre-involving sub-retinal fibrosis or foveal atroptoms.	etional awareness of reduction in vision raphy) subfield > 350 micrometers		
Re-assessment Prerequisites (t  Prescriendors and  and  and  and  and  and  and  and	There is stability or two lines of Snellen visual acuity gain  There is structural improvement on OCT scan (with reduction in Patient's vision is 6/36 or better on the Snellen visual acuity so  There is no centre-involving sub-retinal fibrosis or foveal atrople			

I confirm that the above details are correct:

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PRES	CRIE	BER	PATIENT:
Name	e:		Name:
Ward:	:		NHI:
Secu	ıkin	uma	ıb
			severe chronic plaque psoriasis, second-line biologic t required after 4 months
			(tick boxes where appropriate)
( and		Preso Hosp	cribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.
	and	0	The patient has had an initial Special Authority approval for adalimumab or etanercept, or has trialled infliximab in a Health NZ Hospital, for severe chronic plaque psoriasis
	u		O The patient has experienced intolerable side effects from adalimumab, etanercept or infliximab
		or	O The patient has received insufficient benefit from adalimumab, etanercept or infliximab
	A Psoriasis Area and Severity Index (PASI) assessment or Dermatology Quality of Life Index (DLQI) assessment has been completed for at least the most recent prior treatment course, preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course		
	and	0	The most recent PASI or DQLI assessment is no more than 1 month old at the time of application
Re-a Prero	ssess equis	smen sites	ON – severe chronic plaque psoriasis, second-line biologic tt required after 6 months (tick boxes where appropriate) cribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.
and		or	O Patient's PASI score has reduced by 75% or more (PASI 75) as compared to baseline PASI prior to commencing secukinumab
			O Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing secukinumab
	and	0	Secukinumab to be administered at a maximum dose of 300 mg monthly

I confirm that the above details are correct:

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I confirm that the above details are correct:

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

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

	PATIENT:
ame:	
/ard:	NHI:
ecukinumab	- continued
Re-assessment re	ere chronic plaque psoriasis, first-line biologic quired after 4 months k boxes where appropriate)
O Prescribe Hospital.	ed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and foll A F	Patient has "whole body" severe chronic plaque psoriasis with a Psoriasis Area and Severity Index (PASI) score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis  Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis  Patient has severe chronic localised genital or flexural plaque psoriasis where the plaques or lesions have been present for at least 6 months from the time of initial diagnosis, and with a Dermatology Life Quality Index (DLQI) score greater than 10  tient has tried, but had an inadequate response (see Note) to, or has experienced intolerable side effects from, at least three of the lowing (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, ciclosporin, or acitretin  PASI assessment or Dermatology Quality of Life Index (DLQI) assessment has been completed for at least the most recent prior atment course, preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course e most recent PASI or DQLI assessment is no more than 1 month old at the time of application
soriasis, a PASI secent prior treatmor erythema, thick nore of the face, post recent prior to	course is defined as a minimum of 12 weeks of treatment. "Inadequate response" is defined as: for whole body severe chronic plaque score of greater than 10, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most ent; for severe chronic plaque psoriasis of the face, hand, foot, genital or flexural areas, at least 2 of the 3 PASI symptom sub scores chess and scaling are rated as severe or very severe, and for the face, palm of a hand or sole of a foot the skin area affected is 30% or oalm of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month following cessation of the reatment.  - severe chronic plaque psoriasis, first-line biologic
le-assessment red	quired after 6 months k boxes where appropriate)
or	Patient's PASI score has reduced by 75% or more (PASI 75) as compared to baseline PASI prior to commencing secukinumab  Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing secukinumab
	Patient had severe chronic localised genital or flexural plaque psoriasis at the start of treatment  The patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline value
	Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing secukinumab

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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	e:		Name:
Ward:	:		NHI:
Secu	ıkinum	ab - continued	
Re-a	ssessme	ankylosing spondylitis, second-line biologic ent required after 3 months s (tick boxes where appropriate)	
and		scribed by, or recommended by a rheumatologist, or in accordan pital.	ce with a protocol or guideline that has been endorsed by the Health NZ
	and _	The patient has had an initial Special Authority approval for ad	lalimumab and/or etanercept for ankylosing spondylitis
	o	O The patient has experienced intolerable side effects from	n a reasonable trial of adalimumab and/or etanercept
		O Following 12 weeks of adalimumab and/or etanercept treand/or etanercept for ankylosing spondylitis	eatment, the patient did not meet the renewal criteria for adalimumab
		ON – ankylosing spondylitis, second-line biologic ent required after 6 months	
Prer	equisites	s (tick boxes where appropriate)	
and		scribed by, or recommended by a rheumatologist, or in accordan pital.	ce with a protocol or guideline that has been endorsed by the Health NZ
	and	Following 12 weeks initial treatment of secukinumab treatmen baseline on a 10 point scale, or by 50%, whichever is less	t, BASDAI has improved by 4 or more points from pre-secukinumab
	and	Physician considers that the patient has benefitted from treatments	nent and that continued treatment is appropriate
	O	Secukinumab to be administered at doses no greater than 150	mg monthly

I confirm that the above details are correct:

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.

PRES	ESCRIBER			PATIENT:	
Name	e:				
Ward	:				NHI:
Secu	ıkinı	ımal	<b>)</b> - c	ntinued	
Re-a	equis	ment ites (1	requ ick b	ic arthritis ed after 6 mo xes where ap	
and		Hospit			
		and	0	Patient has ha	d an initial Special Authority approval for adalimumab, etanercept or infliximab for psoriatic arthritis
			or	O Patient	nas experienced intolerable side effects from adalimumab, etanercept or infliximab
					nas received insufficient benefit from adalimumab, etanercept or infliximab to meet the renewal criteria for mab, etanercept or infliximab for psoriatic arthritis
	or				
		and	$\circ$	Patient has ha	d severe active psoriatic arthritis for six months duration or longer
		_	0		ed and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg aximum tolerated dose
		and	0		ed and not responded to at least three months of sulfasalazine at a dose of at least 2 g per day or leflunomide at a 20 mg daily (or maximum tolerated doses)
		unu	or	O Patient	nas persistent symptoms of poorly controlled and active disease in at least 15 swollen, tender joints
		_			nas persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, nee, ankle, and either shoulder or hip
		and		O Patient applicat	nas a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this ion
			or	O Patient	nas an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour
			<u> </u>	O ESR an and has	d CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day done so for more than three months
Re-a	ssess	ment	requ	oriatic arthri ed after 6 mo xes where ap	nths
(					
Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been er Hospital.				ended by a meumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ	
		or	0		4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a ficant response to treatment in the opinion of the physician
			0		emonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant rior secukinumab treatment in the opinion of the treating physician
	and	C	Secu	inumab to be	administered at doses no greater than 300 mg monthly

I confirm that the above details are correct:

RESCRIBER	PATIENT:
ame:	
ard:	NHI:
astuzuma	b emtansine
	early breast cancer (tick boxes where appropriate)
	Patient has early breast cancer expressing HER2 IHC3+ or ISH+  Documentation of pathological invasive residual disease in the breast and/or auxiliary lymph nodes following completion of surgery  Patient has completed systemic neoadjuvant therapy with trastuzumab and chemotherapy prior to surgery  Disease has not progressed during neoadjuvant therapy  Patient has left ventricular ejection fraction of 45% or greater  Adjuvant treatment with trastuzumab emtansine to be commenced within 12 weeks of surgery  Trastuzumab emtansine to be discontinued at disease progression  Total adjuvant treatment duration must not exceed 42 weeks (14 cycles)
Re-assessmer	nt required after 6 months (tick boxes where appropriate)
and and	Patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)  Patient has previously received trastuzumab and chemotherapy, separately or in combination
or	O The patient has received prior therapy for metastatic disease*  O The patient developed disease recurrence during, or within six months of completing adjuvant therapy*
and and	Patient has a good performance status (ECOG 0-1)
or	O Patient does not have symptomatic brain metastases O Patient has brain metastases and has received prior local CNS therapy
and	O Patient has discontinued trastuzumab deruxtecan due to intolerance and
	The cancer did not progress while on trastuzumab deruxtecan

I confirm that the above details are correct:

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Trastuzumab emtansine - continued		
CONTINUATION – metastatic breast cancer Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)		
O The cancer has not progressed at any time point during the previous approval period whilst on trastuzumab emtansine and		
Treatment to be discontinued at disease progression		
Note: *Note: Prior or adjuvant therapy includes anthracycline, other chemoth	erapy, biological drugs, or endocrine therapy.	

#### RS1973 - Rituximab

ABO-incompatible organ transplant - INITIATION	
ANCA associated vasculitis - INITIATION	
ANCA associated vasculitis - CONTINUATION	360
Antibody-mediated organ transplant rejection - INITIATION	
B-cell acute lymphoblastic leukaemia/lymphoma* - INITIATION	
CD20+ low grade or follicular B-cell NHL - INITIATION	
CD20+ low grade or follicular B-cell NHL - CONTINUATION	
Chronic lymphocytic leukaemia - INITIATION	
Chronic lymphocytic leukaemia - CONTINUATION	
Membranous nephropathy - INITIATION	367
Membranous nephropathy - CONTINUATION	367
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Steroid dependent nephrotic syndrome (SDNS) or frequently relapsing nephrotic syndrome (FRNS) -	INITIATION
362	ONTINU IATION
Steroid dependent nephrotic syndrome (SDNS) or frequently relapsing nephrotic syndrome (FRNS) - Co	ONTINUATION
362	
Steroid resistant nephrotic syndrome (SRNS) - INITIATION	362
Steroid resistant nephrotic syndrome (SRNS) - CONTINUATION	
Aggressive CD20 positive NHL - INITIATION	355
Aggressive CD20 positive NHL - CONTINUATION	
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Anti-NMDA receptor autoimmune encephalitis - CONTINUATION	366
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Immune thrombocytopenic purpura (ITP) - INITIATION	
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Pemiphigus* - CONTINUATION	369
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Post-transplant - CONTINUATION	
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Pure red cell aplasia (PRCA) - CONTINUATION	
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Severe chronic inflammatory demyelinating polyneuropathy - CONTINUATION	365
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Severe cold haemagglutinin disease (CHAD) - CONTINUATION	35/
Thrombotic thrombocytopenic purpura (TTP) - INITIATION	359
Thrombotic thrombocytopenic purpura (TTP) - CONTINUATION	359
Treatment refractory systemic lupus erythematosus (SLE) - INITIATION	361
Treatment refractory systemic lupus erythematosus (SLE) - CONTINUATION	361
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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:	
/ard:NHI:		
Rituximab (Riximyo)		
INITIATION – haemophilia with inhibitors  Prerequisites (tick boxes where appropriate)		
O Prescribed by, or recommended by a haematologist, or in accordance Hospital.	ce with a protocol or guideline that has been endorsed by the Health NZ	
Patient has mild congenital haemophilia complicated by inhibit	tors	
O Patient has severe congenital haemophilia complicated by inh	ibitors and has failed immune tolerance therapy	
O Patient has acquired haemophilia		
CONTINUATION – haemophilia with inhibitors  Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a haematologist, or in accordance	be with a protocol or guideline that has been endorsed by the Health NZ	
Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
Patient was previously treated with rituximab for haemophilia vand  An initial response lasting at least 12 months was demonstrate		
and Patient now requires repeat treatment		
INITIATION – post-transplant Prerequisites (tick boxes where appropriate)		
O The patient has B-cell post-transplant lymphoproliferative diso	rder*	
O To be used for a maximum of 8 treatment cycles  Note: Indications marked with * are unapproved indications.		
CONTINUATION – post-transplant Prerequisites (tick boxes where appropriate)		
O The patient has had a rituximab treatment-free interval of 12 n	nonths or more	
The patient has B-cell post-transplant lymphoproliferative diso and	rder*	
O To be used for no more than 6 treatment cycles  Note: Indications marked with * are unapproved indications.		

PRESCRI	BER		PATIENT:
Name:	Name:Name:		
Ward: NHI:			NHI:
Rituxima	<b>ab</b> (Riximy	ro) - continued	
Re-asses	sment requ	ent, low-grade lymphomas or hairy cell leukaemia* uired after 9 months poxes where appropriate)	
	and O	The patient has indolent low grade NHL or hairy cell leuk  To be used for a maximum of 6 treatment cycles	kaemia* with relapsed disease following prior chemotherapy
Or Note:	and O	To be used for a maximum of 6 treatment cycles	cell leukaemia* requiring first-line systemic chemotherapy
		grade lymphomas includes follicular, mantie, marginal zol Il leukaemia' also includes hairy cell leukaemia variant.	ne and lymphoplasmacytic/Waldenstrom macroglobulinaemia. *Unapproved
Re-asses	sment requ	ndolent, low-grade lymphomas or hairy cell leukaemia uired after 12 months poxes where appropriate)	a*
and	The I	patient has had a rituximab treatment-free interval of 12 m patient has indolent, low-grade NHL or hairy cell leukaem e used for no more than 6 treatment cycles	ia* with relapsed disease following prior chemotherapy
		grade lymphomas' includes follicular, mantle, marginal zoi Il leukaemia' also includes hairy cell leukaemia variant.	ne and lymphoplasmacytic/Waldenstrom macroglobulinaemia. *Unapproved
		essive CD20 positive NHL poxes where appropriate)	
	and on and	The patient has treatment naive aggressive CD20 position.  To be used with a multi-agent chemotherapy regimen give.  To be used for a maximum of 8 treatment cycles.	
or	and	The patient has aggressive CD20 positive NHL with relation to be used for a maximum of 6 treatment cycles	psed disease following prior chemotherapy
Note: 'Ag	gressive Cl	D20 positive NHL' includes large B-cell lymphoma and Bu	rkitt's lymphoma/leukaemia.

I confirm that the above details are correct:

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:	
Nard:	NHI:
<b>Rituximab</b> (Rixi	imyo) - continued
	- aggressive CD20 positive NHL ck boxes where appropriate)
and The	the patient has had a rituximab treatment-free interval of 12 months or more  the patient has relapsed refractory/aggressive CD20 positive NHL  to be used with a multi-agent chemotherapy regimen given with curative intent  to be used for a maximum of 4 treatment cycles
INITIATION – Chi Re-assessment re	c CD20 positive NHL' includes large B-cell lymphoma and Burkitt's lymphoma/leukaemia.  ronic lymphocytic leukaemia equired after 12 months ck boxes where appropriate)
O Th	he patient has progressive Binet stage A, B or C chronic lymphocytic leukaemia (CLL) requiring treatment
or	The patient is rituximab treatment naive
or	The patient is chemotherapy treatment naive  The patient's disease has relapsed following no more than three prior lines of chemotherapy treatment and  The patient has had a treatment-free interval of 12 months or more if previously treated with fludarabine and cyclophosphamide chemotherapy
	The patient's disease has relapsed within 36 months of previous treatment and rituximab treatment is to be used in combination with funded venetoclax
and The and	he patient has good performance status
or	The patient does not have chromosome 17p deletion CLL  Rituximab treatment is to be used in combination with funded venetoclax for relapsed/refractory chronic lymphocytic leukaemia
and 6	ituximab to be administered in combination with fludarabine and cyclophosphamide, bendamustine or venetoclax for a maximum of treatment cycles is planned that the patient receives full dose fludarabine and cyclophosphamide (orally or dose equivalent intravenous administration), endamustine or venetoclax
Note: 'Chronic lyr standard theraped temporarily debilit	mphocytic leukaemia (CLL)' includes small lymphocytic lymphoma. A line of chemotherapy treatment is considered to comprise a known utic chemotherapy regimen and supportive treatments. 'Good performance status' means ECOG score of 0-1, however, in patients tated by their CLL disease symptoms a higher ECOG (2 or 3) is acceptable where treatment with rituximab is expected to improve approve ECOG score to < 2.

I confirm that the above details are correct:

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

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER PATIENT:
lame: Name:
Vard: NHI:
Rituximab (Riximyo) - continued
CONTINUATION – Chronic lymphocytic leukaemia Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)
The patient's disease has relapsed within 36 months of previous treatment and rituximab treatment is to be used in combination with funded venetoclax  The patient's disease has relapsed following no more than one prior line of treatment with rituximab for CLL  and  The patient has had an interval of 36 months or more since commencement of initial rituximab treatment  The patient does not have chromosome 17p deletion CLL  and  It is planned that the patient receives full dose fludarabine and cyclophosphamide (orally or dose equivalent intravenous administration) or bendamustin  and  Rituximab to be administered in combination with fludarabine and cyclophosphamide, bendamustine or venetoclax for a maximum of 6 treatment cycles  Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma. A line of chemotherapy treatment is considered to comprise a known
INITIATION – severe cold haemagglutinin disease (CHAD) Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Patient has cold haemagglutinin disease*  and  Patient has severe disease which is characterized by symptomatic anaemia, transfusion dependence or disabling circulatory symptoms  and  The total rituximab dose used would not exceed the equivalent of 375 mg/m2 of body surface area per week for a total of 4 weeks
Note: Indications marked with * are unapproved indications.
CONTINUATION – severe cold haemagglutinin disease (CHAD)  Re-assessment required after 8 weeks  Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
Or Previous treatment with lower doses of rituximab (100 mg weekly for 4 weeks) have proven ineffective and treatment with higher doses (375 mg/m² weekly for 4 weeks) is now planned  O Patient was previously treated with rituximab for severe cold haemagglutinin disease*  and O An initial response lasting at least 12 months was demonstrated and O Patient now requires repeat treatment
Note: Indications marked with * are unapproved indications.

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:
Rituximab (Riximyo) - continued	
INITIATION – warm autoimmune haemolytic anaemia (warm AIHA) Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by a haematologist, or in accordance Hospital.	e with a protocol or guideline that has been endorsed by the Health NZ
> 5 mg prednisone daily), cytotoxic agents (e.g. cyclophospha	(including if patient requires ongoing steroids at doses equivalent to mide monotherapy or in combination), intravenous immunoglobulin tof 375 mg/m2 of body surface area per week for a total of 4 weeks
Note: Indications marked with * are unapproved indications.	
CONTINUATION – warm autoimmune haemolytic anaemia (warm AIHA) Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by a haematologist, or in accordance Hospital.	e with a protocol or guideline that has been endorsed by the Health NZ
O Previous treatment with lower doses of rituximab (100 mg wee doses (375 mg/m² weekly for 4 weeks) is now planned or	ekly for 4 weeks) have proven ineffective and treatment with higher
Patient was previously treated with rituximab for warm a and  An initial response lasting at least 12 months was demo	
O Patient now requires repeat treatment	
Note: Indications marked with * are unapproved indications.	
INITIATION – immune thrombocytopenic purpura (ITP) Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a haematologist, or in accordance Hospital.	e with a protocol or guideline that has been endorsed by the Health NZ
O Patient has immune thrombocytopenic purpura* with a p	platelet count of less than or equal to 20,000 platelets per microlitre
	latelet count of 20,000 to 30,000 platelets per microlitre and significant
Treatment with steroids and splenectomy have been ine or  Treatment with steroids has been ineffective and splene	
or	e and patient is being prepared for elective surgery (e.g. splenectomy)
and  The total rituximab dose used would not exceed the equivalen	t of 375 mg/m2 of body surface area per week for a total of 4 weeks
Note: Indications marked with * are unapproved indications.	
I confirm that the above details are correct:	

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.

PRES	CRII	BER PATIENT:		
Name	:	Name:		
Ward:	Nard: NHI:			
Ritux	ima	ab (Riximyo) - continued		
Re-as	sses	JATION – immune thrombocytopenic purpura (ITP) sment required after 8 weeks sites (tick boxes where appropriate)		
and		Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
	Previous treatment with lower doses of rituximab (100 mg weekly for 4 weeks) have proven ineffective and treatment wit doses (375 mg/m² weekly for 4 weeks) is now planned or			
		O Patient was previously treated with rituximab for immune thrombocytopenic purpura*		
		An initial response lasting at least 12 months was demonstrated and Patient now requires repeat treatment		
Note:	Ind	ications marked with * are unapproved indications.		
and	and	sment required after 8 weeks sites (tick boxes where appropriate)  Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  The total rituximab dose used would not exceed the equivalent of 375 mg/m2 of body surface area per week for a total of 4 weeks  Patient has thrombotic thrombocytopenic purpura* and has experienced progression of clinical symptoms or persistent thrombocytopenia despite plasma exchange  Patient has acute idiopathic thrombotic thrombocytopenic purpura* with neurological or cardiovascular pathology  ications marked with * are unapproved indications.		
		JATION – thrombotic thrombocytopenic purpura (TTP)		
		sment required after 8 weeks sites (tick boxes where appropriate)		
and		Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
	and			
	and	O Patient now requires repeat treatment		
Note:	Ind	ications marked with * are unapproved indications.		
		· · · · · · · · · · · · · · · · · · ·		

I confirm that the above details are correct:

Cianad.	Doto.	
Sidned.	 Date.	

I confirm that the above details are correct:

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

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Rituximab (Riximyo) - continued	
INITIATION – pure red cell aplasia (PRCA) Re-assessment required after 6 weeks Prerequisites (tick box where appropriate)  Prescribed by, or recommended by a haematologist, or in accordance Hospital.  and Patient has autoimmune pure red cell aplasia* associated with a der Note: Indications marked with * are unapproved indications.	ce with a protocol or guideline that has been endorsed by the Health NZ monstrable B-cell lymphoproliferative disorder
Hospital.	ee with a protocol or guideline that has been endorsed by the Health NZ  * associated with a demonstrable B-cell lymphoproliferative disorder and
or disease after at least 3 months	clophosphamide has failed to achieve significant improvement of osphamide > 15 g or a further repeat 3 month induction course of 15 g
CONTINUATION – ANCA associated vasculitis Re-assessment required after 8 weeks	
Prerequisites (tick boxes where appropriate)  Patient has been diagnosed with ANCA associated vasculitis* and Patient has previously responded to treatment with rituximab band The total rituximab dose would not exceed the equivalent of 37.  Note: Indications marked with * are unapproved indications.	

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:	
Rituximab (Riximyo) - continued		
INITIATION – treatment refractory systemic lupus erythematosus (SLE) Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a rheumatologist or nephrologist the Health NZ Hospital.  and  The patient has severe, immediately life- or organ-threatening and  The disease has proved refractory to treatment with steroids a and	at a dose of at least 1 mg/kg  6 months with maximal tolerated doses of azathioprine, mycophenolate	
Note: Indications marked with * are unapproved indications.		
CONTINUATION – treatment refractory systemic lupus erythematosus (Since Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a rheumatologist or nephrologist the Health NZ Hospital.  Patient's SLE* achieved at least a partial response to the prevand  The disease has subsequently relapsed and  Maximum of two 1000 mg infusions of rituximab  Note: Indications marked with * are unapproved indications.	, or in accordance with a protocol or guideline that has been endorsed by	
INITIATION – Antibody-mediated organ transplant rejection Prerequisites (tick box where appropriate)  O Patient has been diagnosed with antibody-mediated organ transplant rejection* Note: Indications marked with * are unapproved indications.		
INITIATION – ABO-incompatible organ transplant Prerequisites (tick box where appropriate)  O Patient is to undergo an ABO-incompatible solid organ transplant* Note: Indications marked with * are unapproved indications.		

I confirm that the above details are correct:

Signed: Date:

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

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Rituximab (Riximyo) - continued	
Hospital.  O Patient is a child with SDNS* or FRNS*  and	ntly relapsing nephrotic syndrome (FRNS)  e with a protocol or guideline that has been endorsed by the Health NZ  been ineffective or associated with evidence of steroid toxicity
Treatment with ciclosporin for at least a period of 3 months h and Treatment with mycophenolate for at least a period of 3 months h and	as been ineffective and/or discontinued due to unacceptable side effects ths with no reduction in disease relapses ent of 375 mg/m² of body surface area per week for a total of 4 weeks
Note: Indications marked with a * are unapproved indications.	
Hospital.  Patient who was previously treated with rituximab for nephro and  Treatment with rituximab was previously successful and has relapsed and the patient now requires repeat treatment and	e with a protocol or guideline that has been endorsed by the Health NZ
Hospital.  Patient is a child with SRNS* where treatment with steroids a and  Treatment with tacrolimus for at least 3 months has been ine and  Genetic causes of nephrotic syndrome have been excluded and	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Rituximab (Riximyo) - continued	
CONTINUATION – Steroid resistant nephrotic syndrome (SRNS) Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a nephrologist, or in accordance Hospital.  and	with a protocol or guideline that has been endorsed by the Health NZ
Patient who was previously treated with rituximab for nephrotic and  Treatment with rituximab was previously successful and has d condition has relapsed and the patient now requires repeat treatment	emonstrated sustained response for greater than 6 months, but the
INITIATION – Neuromyelitis Optica Spectrum Disorder (NMOSD) Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  One of the following dose regimens is to be used: 2 doses of weekly for four weeks	1,000 mg rituximab administered fortnightly, or 4 doses of 375 mg/m2 administered
and	of NMOSD (rapidly progressing symptoms and clinical investigations
The patient has experienced a breakthrough attact and The patient is receiving treatment with mycopheno and The patients is receiving treatment with corticoster	plate
CONTINUATION – Neuromyelitis Optica Spectrum Disorder (NMOSD) Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)	
One of the following dose regimens is to be used: 2 doses of weekly for four weeks  and  The patients has responded to the most recent course of rituxiand  The patient has not received rituximab in the previous 6 month	

I confirm that the above details are correct:		
Cianad	Doto	

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

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER PATIENT:			
Name: .			
Ward:	Ward: NHI:		
Rituxin	nab (F	Riximyo) - continued	
Re-asse	essmen uisites	Severe Refractory Myasthenia Gravis It required after 2 years (tick boxes where appropriate)  cribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ itial.  One of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg once weekly for four weeks, or two 1,000 mg doses given two weeks apart	
ar	or	Treatment with corticosteroids and at least one other immunosuppressant for at least a period of 12 months has been ineffective  Treatment with at least one other immunosuppressant for a period of at least 12 months  Corticosteroids have been trialed for at least 12 months and have been discontinued due to unacceptable side effects	
Prerequ	essmen uisites	ON – Severe Refractory Myasthenia Gravis It required after 2 years (tick boxes where appropriate)  cribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.	
and	$\circ$	One of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg once weekly for four weeks, or two 1,000 mg doses given two weeks apart  An initial response lasting at least 12 months was demonstrated	
	or	The patient has relapsed despite treatment with corticosteroids and at least one other immunosuppressant for a period of at least 12 months  The patient's myasthenia gravis has relapsed despite treatment with at least one immunosuppressant for a period of at least 12 months  Corticosteroids have been trialed for at least 12 months and have been discontinued due to unacceptable side effects	
Re-asse	essmen	Severe antisynthetase syndrome It required after 12 months (tick boxes where appropriate)	
ar	$\circ$	Patient has confirmed antisynthetase syndrome  Patient has severe, immediately life or organ threatening disease, including interstitial lung disease	
ar	or	Treatment with at least 3 immunosuppressants (oral steroids, cyclophosphamide, methotrexate, mycophenolate, ciclosporin, azathioprine) has not be effective at controlling active disease  Rapid treatment is required due to life threatening complications	
di	<u></u>	Maximum of four 1,000 mg infusions of rituximab	

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

PRESCRIBER	PATIENT:
Name:	
Ward:	NHI:
Rituximab (F	Riximyo) - continued
Re-assessmer	ON – Severe antisynthetase syndrome t required after 12 months (tick boxes where appropriate)
and on and	Patient's disease has responded to the previous rituximab treatment with demonstrated improvement in inflammatory markers, muscle strength and pulmonary function  The patient has not received rituximab in the previous 6 months  Maximum of two cycles of 2 × 1,000 mg infusions of rituximab given two weeks apart
	graft versus host disease (tick boxes where appropriate)
and and	Patient has refractory graft versus host disease following transplant  Treatment with at least 3 immunosuppressants (oral steroids, ciclosporin, tacrolimus, mycophenolate, sirolimus) has not be effective at controlling active disease
	The total rituximab dose used would not exceed the equivalent of 375 mg/m² of body surface area per week for a total of 4 weeks
Prerequisites	t required after 6 months (tick boxes where appropriate) cribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.
and	Patient has severe chronic inflammatory demyelinating polyneuropathy (CIPD)
	Treatment with steroids and intravenous immunoglobulin and/or plasma exchange has not been effective at controlling active disease  At least one other immunosuppressant (cyclophosphamide, ciclosporin, tacrolimus, mycophenolate) has not been effective at controlling active disease
or	O Rapid treatment is required due to life threatening complications
and	One of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg once weekly for four weeks, or two 1,000 mg doses given two weeks apart
Re-assessmer	ON – severe chronic inflammatory demyelinating polyneuropathy t required after 6 months (tick boxes where appropriate)
O	Patient's disease has responded to the previous rituximab treatment with demonstrated improvement in neurological function compared to baseline
and	The patient has not received rituximab in the previous 6 months
	One of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg once weekly for four weeks, or two 1,000 mg doses given two weeks apart

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.

PRES	PRESCRIBER		PATIENT:		
Name:	lame: Name:				
Ward:	ard:NHI:				
Ritux	ima	ab (R	liximyo) - continued		
Re-as	sess quis	smen sites Presc	anti-NMDA receptor autoimmune encephalitis t required after 6 months (tick boxes where appropriate)  cribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ		
Hospital.  O Patient has severe anti-NMDA receptor autoimmune encephalitis					
	and		ratient has severe anti-nividal receptor autominume encephantis		
			Treatment with steroids and intravenous immunoglobulin and/or plasma exchange has not been effective at controlling active disease  At least one other immunosuppressant (cyclophosphamide, ciclosporin, tacrolimus, mycophenolate) has not been effective at controlling active disease		
		or	O Rapid treatment is required due to life threatening complications		
	and (	0	One of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg once weekly for four weeks, or two 1,000 mg doses given two weeks apart		
	quisi	Preso	trequired after 6 months (tick boxes where appropriate)  cribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.  Patient's disease has responded to the previous rituximab treatment with demonstrated improvement in neurological function  The patient has not received rituximab in the previous 6 months  The patient has experienced a relapse and now requires further treatment  One of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg once weekly for four weeks, or two 1,000 mg doses given two weeks apart		
Re-as	sess	smen	CD20+ low grade or follicular B-cell NHL t required after 9 months (tick boxes where appropriate)		
	or	and	O To be used for a maximum of 6 treatment cycles  O The patient has CD20+ low grade or follicular B-cell NHL requiring first-line systemic chemotherapy		

I confirm that the above details are correct:

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

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

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIE	ENT:
Name:	Name	y:
Ward:	NHI:	
<b>Rituximab</b> (Bi	Riximyo) - continued	
CONTINUATION Re-assessment Prerequisites (	DN – CD20+ low grade or follicular B-cell NHL nt required after 24 months (tick boxes where appropriate)  Rituximab is to be used for maintenance in CD20+ low grade or follic chemotherapy  Patient is intended to receive rituximab maintenance therapy for 2 years.	
	12 cycles)	and at a dose of 676 Highliz every 6 weeks (maximum of
Re-assessment	Membranous nephropathy nt required after 6 weeks (tick boxes where appropriate)	
or	O Patient has biopsy-proven primary/idiopathic membranous nep O Patient has PLA2 antibodies with no evidence of secondary ca	
and	Patient remains at high risk of progression to end-stage kidney disea measures (see Note)  The total rituximab dose would not exceed the equivalent of 375mg/r	
Re-assessment	ON – Membranous nephropathy nt required after 6 weeks (tick boxes where appropriate)	
and	Patient was previously treated with rituximab for membranous nephro	opathy*
or	O Treatment with rituximab was previously successful, but the co treatment	ndition has relapsed, and the patient now requires repeat
	O Patient achieved partial response to treatment and requires rep	peat treatment (see Note)
and	The total rituximab dose used would not exceed the equivalent of 375	5 mg/m2 of body surface area per week for a total of 4 weeks
<ul><li>b) High risk of p</li><li>c) Conservative</li></ul>	marked with * are unapproved indications.  f progression to end-stage kidney disease defined as > 5g/day proteing the measures include renin-angiotensin system blockade, blood-pressunia, and anticoagulation agents unless contraindicated or the patient h	ire management, dietary sodium and protein restriction, treatment of
d) Partial respo	ponse defined as a reduction of proteinuria of at least 50% from baseling	ne, and between 0.3 grams and 3.5 grams per 24 hours.

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:
Rituximab (Riximyo) - continued	
INITIATION – B-cell acute lymphoblastic leukaemia/lymphoma* Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)	
Patient has newly diagnosed B-cell acute lymphoblastic leukae and Treatment must be in combination with an intensive chemother and The total rituximab dose would not exceed the equivalent of 37  Note: Indications marked with * are unapproved indications.	rapy protocol with curative intent
INITIATION – desensitisation prior to transplant Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate)	
Patient requires desensitisation prior to mismatched allogenic  O Patient would receive no more than two doses at 375 mg/m2 control.  Note: Indications marked with * are unapproved indications.	
INITIATION – pemiphigus* Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a dermatologist or relevant speci by the Health NZ Hospital.  and	alist, or in accordance with a protocol or guideline that has been endorsed
Patient has severe rapidly progressive pemphigus and Is used in combination with systemic corticosteroids (20 and O Skin involvement is at least 5% body surface area or O Significant mucosal involvement (10 or more muco or O Involvement of two or more mucosal sites  or O Patient has pemphigus and	mg/day)  psal erosions) or diffuse gingivitis or confluent large erosions  m systemic corticosteroids (20 mg/day) in combination with a steroid
Note: Indications marked with * are unapproved indications.	

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:
Rituximab (Riximyo) - continued	
CONTINUATION – pemiphigus* Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a dermatologist or relevant speciby the Health NZ Hospital.	alist, or in accordance with a protocol or guideline that has been endorsed
Patient has experienced adequate clinical benefit from rituximal ulceration and reduction in corticosteroid requirement  and Patient has not received rituximab in the previous 6 months  Note: Indications marked with * are unapproved indications.	ab treatment, with improvement in symptoms and healing of skin
INITIATION – immunoglobulin G4-related disease (IgG4-RD*) Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate)	
lowering corticosteroid dose below 5 mg per day (predni	anti-rheumatic drugs is contraindicated or associated with evidence of
Note: Indications marked with * are unapproved indications.	
CONTINUATION – immunoglobulin G4-related disease (IgG4-RD*) Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
but the condition has relapsed O Patient is receiving maintenance treatment for IgG4-RD2 and O Rituximab re-treatment not to be given within 6 months of prevand	rious course of treatment
Maximum of two 1000 mg infusions of rituximab given two wee	eks apart
Note: Indications marked with * are unapproved indications.	

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.

PRES	CRIBI	ER	PATIENT:
Name:			Name:
Ward: NHI:			
Мер	olizuı	mal	b
INITI Re-a	ATION ssessr equisi	resc ndor	Severe eosinophilic asthma at required after 12 months (tick boxes where appropriate)  cribed by, or recommended by a respiratory physician or clinical immunologist, or in accordance with a protocol or guideline that has been resed by the Health NZ Hospital.  Patient must be aged 12 years or older  Patient must have a diagnosis of severe eosinophilic asthma documented by a respiratory physician or clinical immunologist  Conditions that mimic asthma eg. vocal cord dysfunction, central airway obstruction, bronchiolitis etc. have been excluded
	and (and and	C	Patient has a blood eosinophil count of greater than 0.5 × 10°9 cells/L in the last 12 months  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  O 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  O 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			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
		or	Patient has not previously received an anti-IL5 biological therapy for their severe eosinophilic asthma  Patient was refractory or intolerant to previous anti-IL5 biological therapy  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	and	or	An increase in the Asthma Control Test (ACT) score of at least 5 from baseline  Control Test (ACT) score of at least 5 from baseline  Exacerbations have been reduced from baseline by 50% as a result of treatment with mepolizumab  Reduction in continuous oral corticosteroid use by 50% or by 10 mg/day while maintaining or improving asthma control

 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:
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 contraindicated to all): azathioprine, cyclophosphamide, leflund	
The patient has trialled prednisone for a minimum of three 7.5 mg per day  Corticosteroids are contraindicated	ee months and is unable to maintain disease control at doses below
CONTINUATION – eosinophilic granulomatosis with polyangiitis Re-assessment required after 12 months Prerequisites (tick box where appropriate)  O Patient has no evidence of clinical disease progression	

I confirm that the above details are correct:

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Oigilica.	 Duic.	

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

PRESCRIBER	PATIENT:
Name:	
Ward:	NHI:
Casirivimat	b and imdevimab
Re-assessme	Treatment of profoundly immunocompromised patients ent required after 2 weeks s (tick boxes where appropriate)
** Examples in	Patient has confirmed (or probable) COVID-19  The patient is in the community (treated as an outpatient) with mild to moderate disease severity*  Patient is profoundly immunocompromised** and is at risk of not having mounted an adequate response to vaccination against COVID-19 or is unvaccinated  Patient's symptoms started within the last 10 days  Patient is not receiving high flow oxygen or assisted/mechanical ventilation  Casirivimab and imdevimab is to be administered at a maximum dose of no greater than 2,400 mg  or moderate disease severity as described on the Ministry of Health Website include B-cell depletive illnesses or patients receiving treatment that is B-Cell depleting.
Prerequisites O Pres	s (tick boxes where appropriate) scribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health Hospital.
and and and and and and	Patient has confirmed (or probable) COVID-19  Patient is an in-patient in hospital with mild to moderate disease severity*  Patient's symptoms started within the last 10 days  Patient is not receiving high flow oxygen or assisted/mechanical ventilation
oi	BMI > 30  Patient is Māori or Pacific ethnicity
and	O Patient is unvaccinated  Patient is seronegative where serology testing is readily available or strongly suspected to be seronegative where serology testing is not available
and	Casirivimab and imdevimab is to be administered at a maximum dose of no greater than 2,400 mg
	o moderate disease severity as described on the Ministry of Health Website v.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-information-specific-audiences/covid-19-advice- ople)

### RS2063 - Adalimumab (Amgevita)

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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.

PRES	CRII	BER		PATIENT:
Name	):			Name:
Ward	:			NHI:
Adal	imu	mab	(Amgevita)	
			Sehcet's disease - severe	
Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been end NZ Hospital.			accordance with a protocol or guideline that has been endorsed by the Health	
and	and	-	The patient has severe Behcet's disease* that is significantly	impacting the patient's quality of life
		or	treatment(s) appropriate for the particular symptom(s)  The patient has severe gastrointestinal, rheumatologic	sculitic symptoms and has not responded adequately to one or more
Note	: Ind	ication	to two or more treatments appropriate for the particula as marked with * are unapproved indications.	r symptom(s)
Re-a	sses equi:	Prescribes (in the state of the	Patient has hidradenitis suppurativa Hurley Stage II or Hurle	t a 90 day trial of systemic antibiotics or patient has demonstrated
Re-a	sses equi:	sment sites (i Prescr NZ Ho	ospital.	accordance with a protocol or guideline that has been endorsed by the Health ory nodules, abscesses, draining fistulae) of 25% or more from baseline

 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:
Adali	imuı	mab	(An	ngevita) - continued
Re-as	ssess	ment	requ	e psoriasis - severe chronic red after 4 months oxes where appropriate)
and		Prescr Hospit		by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
		and	O	Patient has had an initial Special Authority approval for etanercept for severe chronic plaque psoriasis
			or	O Patient has experienced intolerable side effects
			U	O Patient has received insufficient benefit to meet the renewal criteria for etanercept for severe chronic plaque psoriasis
	or			
			or	O Patient has "whole body" severe chronic plaque psoriasis with a (PASI) score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis
			or	O Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis
			Oi	O Patient has severe chronic localised genital or flexural plaque psoriasis where the plaques or lesions have been present for at least 6 months from the time of initial diagnosis, and with a Dermatology Life Quality Index (DLQI) score greater than 10
and O Patient has tried, but had an inadequate response to, or has experienced intolerable side effects from, a following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, ciclosporing and		Patient has tried, but had an inadequate response to, or has experienced intolerable side effects from, at least three of the following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, ciclosporin, or acitretin		
		dia	0	A PASI assessment or (DLQI) assessment has been completed for at least the most recent prior treatment course but no longer than 1 month following cessation of each prior treatment course and is no more than 1 month old at the time of application

I confirm that the above details are correct:	

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

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PRESCRIBER				PATIENT:
Name:				Name:
Ward	l:			NHI:
Ada	limu	mab (	Amgev	ita) - continued
				psoriasis - severe chronic ter 2 years
				where appropriate)
		and	) Patie	nt had "whole body" severe chronic plaque psoriasis at the start of treatment
			0	The patient has experienced a 75% or more reduction in PASI score, or is sustained at this level, when compared with the pre-treatment baseline value
			or O	The patient has a DLQI improvement of 5 or more, when compared with the pre-treatment baseline value
	or			
		and	<b>)</b> Patie	nt had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment
			O	The patient has experienced a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the treatment course baseline values
			or O	The patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline value
	or			
		and	) Patie	nt had severe chronic localised genital or flexural plaque psoriasis at the start of treatment
			or O	The patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline value
			<b>"</b> O	Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing adalimumab
			_	angrenosum
Piei	$\bigcirc$	,		where appropriate)
		Prescrib Hospital	-	recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and		<u> </u>		
	and	$\sim$		pyoderma gangrenosum*
	'			received three months of conventional therapy including a minimum of three pharmaceuticals (e.g. prednisone, ciclosporin, e, or methotrexate) and not received an adequate response
Note	e: Indi	cations	marked v	vith * are unapproved indications.

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: Nam				
Ward			NHI:	
Adal	imu	mal	o (Amgevita) - continued	
Re-a	ssess equis	smer <b>sites</b> Preso	Crohn's disease - adults at required after 6 months (tick boxes where appropriate) cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health lospital.	
	and		Patient has severe active Crohn's disease	
		or	O Patient has a CDAI score of greater than or equal to 300 or HBI score of greater than or equal to 10	
		or	Patient has extensive small intestine disease affecting more than 50 cm of the small intestine	
		or	O Patient has evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel resection	
			O Patient has an ileostomy or colostomy and has intestinal inflammation	
	and	0	Patient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators and corticosteroids	
		<b>sites</b> Preso	trequired after 2 years (tick boxes where appropriate)  cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health lospital.  CDAI score has reduced by 100 points from the CDAI score, or HBI score has reduced 3 points, from when the patient was initiated on adalimumab  CDAI score is 150 or less, or HBI is 4 or less  The patient has demonstrated an adequate response to treatment, but CDAI score and/or HBI score cannot be assessed	
INITIATION – Crohn's disease - children Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)				
Prescribed by, or recommended by an NZ Hospital.			cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health lospital.	
	and	0	Paediatric patient has active Crohn's disease	
		or	O Patient has a PCDAl score of greater than or equal to 30 O Patient has extensive small intestine disease	
	and		Patient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators and corticosteroids	

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.

col or guideline that has been endorsed by the Health initiated on adalimumab			
col or guideline that has been endorsed by the Health			
CONTINUATION – Crohn's disease - fistulising Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  The number of open draining fistulae have decreased from baseline by at least 50% or  There has been a marked reduction in drainage of all fistula(e) from baseline as demonstrated by a reduction in the Fistula Assessment score, together with less induration and patient-reported pain			
:o			

PRESCRIBER			PATIENT:
Name	ə:		Name:
Ward	:		NHI:
Adal	limu	ımab	(Amgevita) - continued
Re-a	asses	sment <b>sites</b> (†	Ocular inflammation - chronic required after 4 months (tick boxes where appropriate) ribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
and	•	NZ Ho	
		O .	The patient has had an initial Special Authority approval for infliximab for chronic ocular inflammation
	or	and	O Patient has severe uveitis uncontrolled with treatment of steroids and other immunosuppressants with a severe risk of vision loss
			Patient is 18 years or older and treatment with at least two other immunomodulatory agents has proven ineffective  Patient is under 18 years and treatment with methotrexate has proven ineffective or is not tolerated at a therapeutic dose  Patient is under 8 years and treatment with steroids or methotrexate has proven ineffective or is not tolerated at a therapeutic dose; or disease requires control to prevent irreversible vision loss prior to achieving a therapeutic dose of methotrexate
Re-a	equi	sment sites (i	N – Ocular inflammation - chronic required after 2 years tick boxes where appropriate) ribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.
anu		O .	The patient has had a good clinical response following 12 weeks' initial treatment
	or		Following each 2 year treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema)
	0.		Following each 2 year treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old

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			F	ATIENT:
Name	Name:			lame:
Ward	:		N	IHI:
Ada	limu	ımab	o (Amgevita) - continued	
INIT Re-a	IATIC	ON - Cosmen	Ocular inflammation - severe nt required after 4 months (tick boxes where appropriate)  cribed by, or recommended by any relevant practitioner, or in accolospital.  Patient has had an initial Special Authority approval for infliximate  Patient has severe, vision-threatening ocular inflammation  Treatment with high-dose steroids (intravenous methineffective at controlling symptoms  Patient developed new inflammatory symptoms while or	requiring rapid control  lylprednisolone) followed by high dose oral steroids has proven
Re-a	asses equi	Presco NZ Ho	DN – Ocular inflammation - severe nt required after 2 years (tick boxes where appropriate)  cribed by, or recommended by any relevant practitioner, or in accolospital.  The patient has had a good clinical response following 3 initial definitions of the patient has had a since the patient has had a since the patient has had as since the patient had been as the patient had be	

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.

PRE	SCRI	BER		PATIENT:
Nam	e:			
Ward	l:			NHI:
Ada	limu	mab	(An	gevita) - continued
Re-a	asses equi:	sment <b>sites</b> (t	requ ick b ibed	ing spondylitis ed after 6 months ees where appropriate) y, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
		and	$\mathcal{O}$	atient has had an initial Special Authority approval for etanercept for ankylosing spondylitis
				The patient has experienced intolerable side effects
			or	The patient has received insufficient benefit to meet the renewal criteria for ankylosing spondylitis
	or			
	NTINU			Patient has a confirmed diagnosis of ankylosing spondylitis for more than six months  Patient has low back pain and stiffness that is relieved by exercise but not by rest  Patient has bilateral sacroillitis demonstrated by radiology imaging  Patient has not responded adequately to treatment with two or more NSAIDs, while patient was undergoing at least 3 months of regular exercise regimen for ankylosing spondylitis  Patient has limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by the following BASMI measures: a modified Schober's test of less than or equal to 4 cm and lumbar side flexion measurement of less than or equal to 10 cm (mean of left and right)  Patient has limitation of chest expansion by at least 2.5 cm below the average normal values corrected for age and gender  BASDAI of at least 6 on a 0-10 scale completed after the 3 month exercise trial, but prior to ceasing any previous tharmacological treatment and is no more than 1 month old at the time of application
			-	od after 2 years k where appropriate)
NZ Hospital.				ons where treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10 point
		scale,	or ar	mprovement in BASDAI of 50%, whichever is less

I confirm that the above details are correct:

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Signed.	Date:	
Oigilica.	 Daic.	

PRES	SCRI	BER	PAT	PATIENT:			
Name	ə:		Nar	ne:			
Ward	:		NH	:			
Ada	limu	ımab (	(Amgevita) - continued				
Re-a	equi	ssment re isites (tic Prescrib	thritis - oligoarticular course juvenile idiopathic equired after 6 months ck boxes where appropriate) ped by, or recommended by a named specialist or rheumatologist Health NZ Hospital.	or in accordance with a protocol or guideline that has been endorsed			
	or	The patient has had an initial Special Authority approval for etanercept for oligoarticular course juvenile idiopathic arthritis (Jand O Patient has experienced intolerable side effects  O Patient has received insufficient benefit to meet the renewal criteria for oligoarticular course JIA  O To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolera and O Patient has had oligoarticular course JIA for 6 months duration or longer  O At least 2 active joints with limited range of motion, pain or tenderness after a 3-month trial of methotrexate (at the maximum tolerated dose)  O Moderate or high disease activity (cJADAS10 score greater than 1.5) with poor prognostic features after a 3-month trial					
continuation – Arthritis - oligoarticular course juvenile idiopathic Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)							
and	0	Prescribed by, or recommended by any relevant practitioner, or in an NZ Hospital.		ance with a protocol or guideline that has been endorsed by the Health			
	Following initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baseline  On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline						

I confirm that the above details are correct:	
Signed:	Date:

PRES	SCRIE	BER		PATIENT:			
Name	e:			Name:			
Ward	:			NHI:			
Adal	dalimumab (Amgevita) - continued						
Re-a	equis	sment <b>sites</b> ( Presc	requ tick b ribed	itis - polyarticular course juvenile idiopathic uired after 6 months boxes where appropriate) d by, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed alth NZ Hospital.			
		and	O	Patient has had an initial Special Authority approval for etanercept for polyarticular course juvenile idiopathic arthritis (JIA)			
			or	Patient has experienced intolerable side effects  Patient has received insufficient benefit to meet the renewal criteria for polyarticular course JIA			
	or	and (and	$\circ$	O Moderate or high disease activity (cJADAS10 score of at least 2.5) after a 3-month trial of methotrexate (at the maximum tolerated dose)			
CONTINUATION – Arthritis - polyarticular course juvenile idiopathic Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)  Or Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guin NZ Hospital.				uired after 2 years boxes where appropriate) d by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health	1		
and	or	0	asse On s	owing initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global essment from baseline subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued			
			impro	rovement in physician's global assessment from baseline	J		

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.

PRESC	RIBE	R	PATIENT:		
Name:					
Ward:			NHI:		
Adaliı	num	ab (	ngevita) - continued		
Re-ass	sessm quisite ) Pre	ent re es (tic	itis - psoriatic uired after 6 months coxes where appropriate) by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ		
	(	and	Patient has had an initial Special Authority approval for etanercept or secukinumab for psoriatic arthritis		
			O Patient has experienced intolerable side effects O Patient has received insufficient benefit to meet the renewal criteria for psoriatic arthritis		
	or				
		and and		Patient has had active psoriatic arthritis for six months duration or longer  Patient has tried and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated Patient has tried and not responded to at least three months of sulfasalazine or leflunomide at maximum tolerated doses (unless contraindicated)	1)
	•	and	O Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen joints O Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip		
	•		O Patient has CRP level greater than 15 mg/L measured no more than one month prior to the date of this application O Patient has an elevated ESR greater than 25 mm per hour ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months		
Re-ass	sessm quisite	ent re es (tic	Arthritis - psoriatic uired after 2 years boxes where appropriate)  by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Healt	th	
and		. Hosp	al.		
	or _	res	owing initial treatment, the patient has at least a 50% decrease in swollen joint count from baseline and a clinically significant onse in the opinion of the physician		
			ent demonstrates at least a continuing 30% improvement in swollen joint count from baseline and a clinically significant response e opinion of the treating physician		

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.

RIBER		PAHENI:	PATIENT:		
		Name:			
		NHI:			
umal	b (An	Amgevita) - continued			
ION – essmer uisites	Arthrift nt requal	chritis - rheumatoid equired after 6 months ck boxes where appropriate)	n endorsed by the Health NZ		
an	O	The patient has had an initial Special Authority approval for etanercept for rheumatoid arthritis			
	or	O The patient has experienced intolerable side effects			
		O The patient has received insufficient benefit from etanercept to meet the renewal criteria for rh	eumatoid arthritis		
r _					
ar		Patient has had rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic ci antibody positive) for six months duration or longer  Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrex intolerance.			
	$\bigcirc$	Patient has tried and not responded to at least three months of methotrexate at a maximum tolerated	d dose (unless contraindicated)		
sulphate at maximum tolerated dose		Patient has tried and not responded to at least three months of methotrexate in combination with sull sulphate at maximum tolerated doses (unless contraindicated)	fasalazine and hydroxychloroquir		
	or	O Patient has tried and not responded to at least three months of methotrexate in combination will dose of ciclosporin	ith the maximum tolerated		
		O Patient has tried and not responded to at least three months of therapy at the maximum tolerar alone or in combination with methotrexate	ted dose of leflunomide		
ar		O Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen	joints		
	or	O Patient has persistent symptoms of poorly controlled and active disease in at least four joints felbow, knee, ankle, and either shoulder or hip	from the following: wrist,		
essmer	nt requ	equired after 2 years			
			as been endorsed by the Health		
, O	a clinically significant				
0		oint count from baseline and			
	r ar	and	Name:  NHI:  NHI:		

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

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRES	CRIB	ER	PATIENT:
Name:			
Ward:	:		NHI:
Adal	imur	mab (	Amgevita) - continued
	equis F	ites (tic	Is disease - adult-onset (AOSD)  A boxes where appropriate)  and by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and		and	The patient has had an initial Special Authority approval for etanercept and/or tocilizumab for (AOSD)  O Patient has experienced intolerable side effects from etanercept and/or tocilizumab  Patient has received insufficient benefit from at least a three-month trial of etanercept and/or tocilizumab
	or	and	Patient diagnosed with AOSD according to the Yamaguchi criteria  Patient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, NSAIDs and methotrexate  Patient has persistent symptoms of disabling poorly controlled and active disease
	equis F	ites (tick Prescribe NZ Hosp	quired after 6 months (a boxes where appropriate)  and by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ital.  Itient has active ulcerative colitis
	and ( and	an	Patient's SCCAI score is greater than or equal to 4 Patient's PUCAI score is greater than or equal to 20  tient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators d systemic corticosteroids  rgery (or further surgery) is considered to be clinically inappropriate
Re-a Prero	ssess equis	ATION - ment re ites (tic	- ulcerative colitis quired after 2 years s boxes where appropriate) ed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
and	or (	$\bigcirc$	e SCCAI score has reduced by 2 points or more from the SCCAI score when the patient was initiated on biologic therapy e PUCAI score has reduced by 10 points or more from the PUCAI score when the patient was initiated on biologic therapy

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

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER			PATIENT:	
Name	e:			
Ward	:		NHI:	
Adal	imu	ımak	(Amgevita) - continued	
Re-a	sses equi:	smen sites	ndifferentiated spondyloarthiritis required after 6 months tick boxes where appropriate)	
and		Preso	ribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endors tal.	ed by the Health NZ
	anc		Patient has undifferentiated peripheral spondyloarthritis* with active peripheral joint arthritis in at least four joints frow wrist, elbow, knee, ankle, and either shoulder or hip	om the following:
	and	O 1	Patient has tried and not responded to at least three months of each of methotrexate, sulphasalazine and leflunom tolerated doses (unless contraindicated)	ide, at maximum
		or	O Patient has a CRP level greater than 15 mg/L measured no more than one month prior to the date of this app	olication
		or	O Patient has an ESR greater than 25 mm per hour measured no more than one month prior to the date of this	application
			ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 has done so for more than three months	mg per day and
Note	: Ind	licatio	s marked with * are unapproved indications.	
Re-assessment Prerequisites (t				
	or	0	Following initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinical response to treatment in the opinion of the physician  The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically	
			response in the opinion of the treating physician	, digrimodrit
INITIATION – inflammatory bowel arthritis – axial Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health N				
and		Hosp		
	and		Patient has a diagnosis of active ulcerative colitis or active Crohn's disease	
	and		Patient has axial inflammatory pain for six months or more  Patient is unable to take NSAIDs	
	and	0	Patient has unequivocal sacroiliitis demonstrated by radiological imaging or MRI	
	and	0	Patient has not responded adequately to prior treatment consisting of at least 3 months of an exercise regime sup physiotherapist	ervised by a
	and	O	A BASDAI of at least 6 on a 0-10 scale completed after the 3 month exercise trial, but prior to ceasing any previous treatment	s pharmacological

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.

PRE	SCRIE	BER		PATIENT:			
Nam	e:			Name:			
Ward	l:			NHI:			
Ada	limu	mal	o (Amgevita) - continued				
CON Re-a	NTINU	ATIC	ON – inflammatory bowel arthritis – axial nt required after 2 years (tick box where appropriate)				
and			cribed by, or recommended by any relevant practitioner, or in aclospital.	ecordance with a protocol or guideline that has been endorsed by the Health			
			re treatment has resulted in an improvement in BASDAI of 4 or ovement in BASDAI of 50%, whichever is less	more points from pre-treatment baseline on a 10 point scale, or an			
Re-a	assess	mer	inflammatory bowel arthritis – peripheral not required after 6 months (tick boxes where appropriate)				
and		Preso		ice with a protocol or guideline that has been endorsed by the Health NZ			
	and	O Patient has a diagnosis of active ulcerative colitis or active Crohn's disease					
	and	0	Patient has active arthritis in at least four joints from the following: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder, sternoclavicular				
	and	0	Patient has tried and not experienced a response to at least the dose (unless contraindicated)	nree months of methotrexate, or azathioprine at a maximum tolerated			
	and	0	Patient has tried and not experienced a response to at least the contraindicated)	nree months of sulphasalazine at a maximum tolerated dose (unless			
			O Patient has a CRP level greater than 15 mg/L measured	no more than one month prior to the date of this application			
		or	O Patient has an ESR greater than 25 mm per hour				
		or		viving prednisone therapy at a dose of greater than 5 mg per day and			
CONTINUATION – inflammatory bowel arthritis – peripheral Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)							
and			cribed by, or recommended by any relevant practitioner, or in ad lospital.	ecordance with a protocol or guideline that has been endorsed by the Health			
	or	0	Following initial treatment, the patient has at least a 50% decr response to treatment in the opinion of the physician	ease in active joint count from baseline and a clinically significant			
		$\bigcirc$	Patient demonstrates at least a continuing 30% improvement	in active joint count from baseline in the opinion of the treating physician			

I confirm that the above details are correct:

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

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Palivizumab	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  Palivizumab to be administered during the annual RSV season and  Infant was born in the last 12 months and  Infant was born at less than 32 weeks zero days'  or  Child was born in the last 24 months and  Child has severe lung, airway, neurological support (see Note A) in the community  Or  Child has haemodynamically significated and  Or  Child has unoperated simple or B)  Or  Child has severe pulmonary hy or  Child has severe combined immune deficite transplant  Or  Child has inborn errors of immunity (see Note A)  Child has inborn errors of immunity (see Note A)	gestation  or neuromuscular disease that requires ongoing ventilatory/respiratory  ant heart disease  ongenital heart disease with significant left to right shunt (see Note  ally palliated complex congenital heart disease
infections, confirmed by an immunologist	

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:
Palivizumab - continued	
or  Note A) in the community  Child has haemodynamically significant heart dis	secular disease that requires ongoing ventilatory/respiratory support (see sease eart disease with significant left to right shunt (see Note B) d complex congenital heart disease (see Note C)
or	ned by an immunologist, but has not received a stem cell transplant increase susceptibility to life-threatening viral respiratory infections,

#### Note:

- a) Ventilatory/respiratory support includes those on home oxygen, CPAP/VPAP and those with tracheostomies in situ managed at home
- b) Child requires/will require heart failure medication, and/or child has significant pulmonary hypertension, and/or infant will require surgical palliation/definitive repair within the next 3 months
- c) Mean pulmonary artery pressure more than 25 mmHg
- d) LV Ejection Fraction less than 40%
- e) Inborn errors of immunity include, but are not limited to, IFNAR deficiencies

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:
Gemtuzuma	b ozogamicin	
INITIATION Prerequisites	(tick boxes where appropriate)	
and and	Patient has not received prior chemotherapy for this condition  Patient has de novo CD33-positive acute myeloid leukaemia	
and and	Patient does not have acute promyelocytic leukaemia  Gemtuzumab ozogamicin will be used in combination with star	ndard anthracycline and cytarabine (AraC)
and O	Patient is being treated with curative intent  Patient's disease risk has been assessed by cytogenetic testing	g to be good or intermediate
and	Patient must be considered eligible for standard intensive remi cytarabine (AraC)	ssion induction chemotherapy with standard anthracycline and
	Gemtuzumab ozogamicin to be funded for one course only (or separate doses)	ne dose at 3 mg per m² body surface area or up to 2 vials of 5 mg as

Note: Acute myeloid leukaemia excludes acute promyelocytic leukaemia and acute myeloid leukaemia that is secondary to another haematological disorder (eg myelodysplasia or myeloproliferative disorder).

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Tixagevimab with cilgavimab  INITIATION	
Prerequisites (tick box where appropriate)	
Only if patient meets access criteria (as per https://pharmac.govt.nz distribution process. Refer to the Pharmac website for more information	/Evusheld). Note the supply of treatment is via Pharmac's approved ation about this and stock availability

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

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIB	ER	PATIENT:	
Name:		Name:	
Ward:	j:NHi:		
Benralizu	ıma	b	
Prerequisi Pand	rescendor	Severe eosinophilic asthma t required after 12 months (tick boxes where appropriate)  ribed by, or recommended by a respiratory physician or clinical immunologist, or in accordance with a protocol or guideline that has been sed by the Health NZ Hospital.  Patient must be aged 12 years or older	
and (and (and (and (and (and (and	C C	Patient must have a diagnosis of severe eosinophilic asthma documented by a respiratory physician or clinical immunologist  Conditions that mimic asthma eg. vocal cord dysfunction, central airway obstruction, bronchiolitis etc. have been excluded  Patient has a blood eosinophil count of greater than 0.5 × 10^9 cells/L in the last 12 months  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 anti-inflammatory reliever therapy plus maintenance regimen, unless contraindicated or not tolerated  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	
and ( and ( and	or O	Patient has received continuous oral corticosteroids of at least the equivalent of 10 mg per day over the previous 3 months  Treatment is not to be used in combination with subsidised mepolizumab  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  Patient has not previously received an anti-IL5 biological therapy for their severe eosinophilic asthma  Patient was refractory or intolerant to previous anti-IL5 biological therapy  Patient was not eligible to continue treatment with previous anti-IL5 biological therapy and discontinued within	
		12 months of commencing treatment	
Re-assess Prerequisi	ment ites ( Presc	N – Severe eosinophilic asthma t required after 2 years (tick boxes where appropriate)  ribed by, or recommended by a respiratory physician or clinical immunologist, or in accordance with a protocol or guideline that has been sed by the Health NZ Hospital.	
and	or	An increase in the Asthma Control Test (ACT) score of at least 5 from baseline  Control Test (ACT) score of at least 5 from baseline  Exacerbations have been reduced from baseline by 50% as a result of treatment with benralizumab  Reduction in continuous oral corticosteroid use by 50% or by 10 mg/day while maintaining or improving asthma control	

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

January 2025

R	PATIENT:
	Name:
	NHI:
ab	
- Crohn's disease - adults ent required after 6 months es (tick boxes where appropriate)  Patient is currently on treatment with ustekinumab commenced below at the time of commencing treatment  Patient has active Crohn's disease	d prior to 1 February 2023 and met all remaining criteria (criterion 2)
or  Patient has had an initial approval for prior biologic effects or insufficient benefit to meet renewal criter  Patient meets the initiation criteria for prior band	iologic therapies for Crohn's disease
rion – Crohn's disease - adults ent required after 12 months es (tick boxes where appropriate)	
therapy  CDAI score is 150 or less, or HBI is 4 or less  The patient has experienced an adequate response to tr	eatment, but CDAI score and/or HBI score cannot be assessed
- Crohn's disease - children* ent required after 6 months es (tick boxes where appropriate)	Aprior to 1 February 2022 and mot all remaining criteria (criterion 2)
Delow at the time of commencing treatment  Patient has active Crohn's disease	e therapy and has experienced intolerable side effects or insufficient
	Crohn's disease - adults ent required after 6 months is (tick boxes where appropriate)  Patient is currently on treatment with ustekinumab commenced below at the time of commencing treatment  Patient has active Crohn's disease  Patient has had an initial approval for prior biologic effects or insufficient benefit to meet renewal criter and Other biologics for Crohn's disease are cont  ONN - Crohn's disease - adults ent required after 12 months is (tick boxes where appropriate)  CDAI score has reduced by 100 points, or HBI score has therapy  CDAI score is 150 or less, or HBI is 4 or less  The patient has experienced an adequate response to treduced after 6 months is (tick boxes where appropriate)  Crohn's disease - children* ent required after 6 months is (tick boxes where appropriate)  Patient is currently on treatment with ustekinumab commenced below at the time of commencing treatment  Patient has active Crohn's disease  Patient has had an initial approval for prior biologic benefit to meet renewal criteria

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:
Ustekinumab - continued	
CONTINUATION - Crohn's disease - cl	
Re-assessment required after 12 months <b>Prerequisites</b> (tick boxes where appropriate appr	
O PCDAI score has re	educed by 10 points from when the patient was initiated on biologic therapy
O PCDAI score is 15	or less
O The patient has exp	perienced an adequate response to treatment, but CDAI score cannot be assessed
and	
	ered at a dose no greater than 90 mg every 8 weeks
Note: Indication marked with * is an unap	proved indication.
or  Delow at the time of common and  Patient has active to and  Patient has heffects or ins  Patient has heffects or ins  Patient and	atment with ustekinumab commenced prior to 1 February 2023 and met all remaining criteria (criterion 2) mencing treatment
CONTINUATION – ulcerative colitis Re-assessment required after 12 months Prerequisites (tick boxes where appropr  The SCCAI score h	
	educed by 10 points or more from the PUCAI score since initiation on biologic therapy*
O Ustekinumab will be used	d at a dose no greater than 90 mg intravenously every 8 weeks
Note: Criterion marked with * is for an ur	approved indication.

PRESCR	IBER		PATIENT:
Name:			
Ward:			NHI:
/edoliz	uma	b	
Re-asse	ssme	nt requ	n's disease - adults uired after 6 months poxes where appropriate)
an	O	Patie	ent has active Crohn's disease
	OI	0	Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria (unless contraindicated)
	OI	$\cdot$	Patient has a CDAI score of greater than or equal to 300, or HBI score of greater than or equal to 10
	OI	$\cdot$	Patient has extensive small intestine disease affecting more than 50 cm of the small intestine
	OI	$\cdot$	Patient has evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel resection  Patient has an ileostomy or colostomy, and has intestinal inflammation
an	d d		
	Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response from prior therapy with immunomodulators and corticosteroids  Patient has experienced intolerable side effects from immunomodulators and corticosteroids		
	OI	0	Immunomodulators and corticosteroids are contraindicated
Re-asse	ssme	nt requ	Crohn's disease - adults uired after 2 years coxes where appropriate)
	OI	0	CDAI score has reduced by 100 points, or HBI score has reduced by 3 points, from when the patient was initiated on biologic therapy
		$\circ$	CDAI score is 150 or less, or HBI is 4 or less
	OI	$\circ$	The patient has experienced an adequate response to treatment, but CDAI score and/or HBI score cannot be assessed
an	d O	Vedo	olizumab to administered at a dose no greater than 300 mg every 8 weeks

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:		
Vedo	lizuı	mal	<b>)</b> - cc	ontinued			
Re-a	ssess	men	t requ	n's disease - children* iired after 6 months poxes where appropriate)			
	( and	С	Paec	liatric patient has active Crohn's disease			
		or	0	Patient has had an initial approval for prior biologic theral meet renewal criteria (unless contraindicated)	py and has experienced intolerable side effects or insufficient benefit to		
			$\circ$	Patient has a Paediatric Crohn's Disease Activity Index (	PCDAI) score of greater than or equal to 30		
		or	0	Patient has extensive small intestine disease			
	and	$\overline{}$	_				
		or	$\circ$	Patient has tried but experienced an inadequate respons from prior therapy with immunomodulators and corticoste	e to (including lack of initial response and/or loss of initial response) eroids		
			$\circ$	Patient has experienced intolerable side effects from imm	nunomodulators and corticosteroids		
		or	0	Immunomodulators and corticosteroids are contraindicate	ed		
Note	Indic	catio	n mar	ked with * is an unapproved indication.			
Re-a	ssess	men	t requ	Crohn's disease - children* ired after 2 years oxes where appropriate)			
		or	0	PCDAI score has reduced by 10 points from when the pa	atient was initiated on biologic therapy		
O PCDAI score is 15 or less							
		or	0	The patient has experienced an adequate response to tre	eatment, but CDAI score cannot be assessed		
	and (	С	Vedo	lizumab to administered at a dose no greater than 300mg	every 8 weeks		
Note: Indication marked with * is an unapproved indication.				,			
			-				

0:	D - 1 - 1	
Zigneg.	i jate:	
Oigilica.	 Duic.	

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.

ESCRIBER		PATIENT:			
me:		Name:			
rd:		NHI:			
dolizumab	- co	ontinued			
	requ	ired after 6 months			
erequisites (t	tick b	oxes where appropriate)			
O F	Patie	nt has active ulcerative colitis			
	0	Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria (unless contraindicated)			
or	0	Patient has a SCCAI score is greater than or equal to 4			
or	0	Patient's PUCAI score is greater than or equal to 20*			
and					
	O Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial respons from prior therapy with immunomodulators and corticosteroids				
or	0	Patient has experienced intolerable side effects from immunomodulators and corticosteroids			
	0	Immunomodulators and corticosteroids are contraindicated			
te: Indication	mar	ked with * is an unapproved indication.			
-assessment	requ	Icerative colitis ired after 2 years oxes where appropriate)			
	0	The SCCAI score has reduced by 2 points or more from the SCCAI score since initiation on biologic therapy			
or	0	The PUCAI score has reduced by 10 points or more from the PUCAI score since initiation on biologic therapy *			
and	Vedo	lizumab will be used at a dose no greater than 300 mg intravenously every 8 weeks			
		ked with * is an unapproved indication.			

I confirm that the above details are correct:

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

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Brentuximab			
INITIATION – relapsed/refractory Hodgkin lymphoma Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)			
Patient has relapsed/refractory CD30-positive Hoand Patient is ineligible for autologous stem cell trans	odgkin lymphoma after two or more lines of chemotherapy		
Patient has relapsed/refractory CD30-positive Hoand Patient has previously undergone autologous ste			
Patient has not previously received funded brentuximab vedo and Response to brentuximab vedotin treatment is to be reviewed and Brentuximab vedotin to be administered at doses no greater	d after a maximum of 6 treatment cycles		
CONTINUATION – relapsed/refractory Hodgkin lymphoma Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)			
Patient has achieved a partial or complete response to brent and Treatment remains clinically appropriate and the patient is be			
O Patient is to receive a maximum of 16 total cycles of brentuxi	mab vedotin treatment		
INITIATION – anaplastic large cell lymphoma Re-assessment required after 9 months  Prerequisites (tick boxes where appropriate)			
Patient has relapsed/refractory CD30-positive systemic anap	lastic large cell lymphoma		
Patient has an ECOG performance status of 0-1 and Patient has not previously received brentuximab vedotin			
and  Response to brentuximab vedotin treatment is to be reviewed	d after a maximum of 6 treatment cycles		
and O Brentuximab vedotin to be administered at doses no greater			

I confirm that the above details are correct:

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

PRES	CRIBER		PATIENT:		
Name	:		Name:		
Ward:			NHI:		
Bren	tuximal	• continued			
	CONTINUATION – anaplastic large cell lymphoma Re-assessment required after 9 months				
Prere	equisites	(tick boxes where appropriate)			
	O	Patient has achieved a partial or complete response to brentux	ximab vedotin after 6 treatment cycles		
	and	Treatment remains clinically appropriate and the patient is benefitting from treatment and treatment is being tolerated			
	and	Patient is to receive a maximum of 16 total cycles of brentuxim	nab vedotin treatment		

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Trastuzumab (Herzuma)	
INITIATION – early breast cancer Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
The patient has early breast cancer expressing HER-2 IHC 3- and  Maximum cumulative dose of 106 mg/kg (12 months' treatment	
CONTINUATION – early breast cancer* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
and  The patient received prior adjuvant trastuzumab treatments and  The patient has not previously received lapatinib to an lapatinib  The patient discontinued lapatinib within 3 months on lapatinib  The patient discontinued lapatinib within 3 months on lapatinib  The patient has not progressed at any time point do and  Trastuzumab will not be given in combination with and  Trastuzumab to be administered in combination and	treatment for HER-2 positive metastatic breast cancer s due to intolerable side effects and the cancer did not progress whilst uring the previous 12 months whilst on trastuzumab  pertuzumab
least 12 months between prior (neo)adjuvar and  The patient has good performance status (E  and  Trastuzumab to be discontinued at disease progression  or	nt chemotherapy treatment and diagnosis of metastatic breast cancer
and O Patient has signs of disease progression and O Disease has not progressed during previous treatment	with trastuzumab
Note: * For patients with relapsed HER-2 positive disease who have previous	ly received adjuvant trastuzumab for early breast cancer

I confirm that the above details are correct:

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

I confirm that the above details are correct:

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

### HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

e:	Name:
J:	NHI:
tuzumab	(Herzuma) - continued
TIATION – m assessment	etastatic breast cancer required after 12 months ick boxes where appropriate)
and -	The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)
or	The patient has not previously received lapatinib treatment for HER-2 positive metastatic breast cancer  The patient discontinued lapatinib within 3 months due to intolerable side effects and the cancer did not progress whilst on lapatinib
and	Trastuzumab will not be given in combination with pertuzumab
or	Trastuzumab to be administered in combination with pertuzumab  Patient has not received prior treatment for their metastatic disease and has had a treatment-free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer
and	The patient has good performance status (ECOG grade 0-1)
ATINUATION assessment	Frastuzumab to be discontinued at disease progression  I – metastatic breast cancer required after 12 months ick boxes where appropriate)
NTINUATION assessment	Trastuzumab to be discontinued at disease progression  N – metastatic breast cancer required after 12 months
NTINUATION assessment requisites (t	Trastuzumab to be discontinued at disease progression  I – metastatic breast cancer required after 12 months ick boxes where appropriate)  O The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)  O The cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab
NTINUATION assessment requisites (to and and and and and and and and assessment assessme	Trastuzumab to be discontinued at disease progression  N - metastatic breast cancer required after 12 months ick boxes where appropriate)  The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)  The cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab  Trastuzumab to be discontinued at disease progression  Patient has previously discontinued treatment with trastuzumab for reasons other than severe toxicity or disease progression  Patient has signs of disease progression

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:	
Trastuzumab (Herzuma) - continued		
CONTINUATION – gastric, gastro-oesophageal junction and oesophageal Re-assessment required after 12 months	al cancer	
Prerequisites (tick boxes where appropriate)		
O The cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab		
Trastuzumab to be discontinued at disease progression		

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Trastuzumab deruxtecan		
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)		
Patient has metastatic breast cancer expressing HER-2 IHC3- and Patient has previously received trastuzumab and chemotherap and The patient has received prior therapy for metastatic dis	by, separately or in combination	
The patient developed disease recurrence during, or wit  and Patient has a good performance status (ECOG 0-1)  and Patient has not received prior funded trastuzumab deruxtecan and Treatment to be discontinued at disease progression		
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)		
The cancer has not progressed at any time point during the prand Treatment to be discontinued at disease progression  Note: Prior or adjuvant therapy includes anthracycline, other chemotherapy, by		

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#### Form RS1203 January 2025

#### HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:
Basiliximab	
INITIATION Prerequisites (tick box where appropriate)	
O For use in solid organ transplants	

I confirm that the above details are correct:

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

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Rituximab (Mabthera)		
INITIATION – rheumatoid arthritis - prior TNF inhibitor use Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health N Hospital.  and		
and The patient has experienced intolerable side effector	cts from a reasonable trial of adalimumab and/or etanercept b and/or etanercept, the patient did not meet the renewal criteria for hritis	
and O Rituximab to be used as an adjunct to methotrexate or loor O Patient is contraindicated to both methotrexate and lefluand O Maximum of two 1,000 mg infusions of rituximab given two we	nomide, requiring rituximab monotherapy to be used	

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Signed.	Date:	
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me:			PATIENT:
			Name:
:			NHI:
xima	<b>b</b> (N	labthe	era) - continued
IATION	<b>V – r</b> men	<b>heum</b> t requ	natoid arthritis - TNF inhibitors contraindicated uired after 4 months boxes where appropriate)
Ор		ribed	by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
( and	C	Treat	tment with a Tumour Necrosis Factor alpha inhibitor is contraindicated
and	$\mathcal{O}$		ent has had severe and active erosive rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic linated peptide (CCP) antibody positive) for six months duration or longer
and	$\sim$	maxi	ent has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a mum tolerated dose
and			ent has tried and not responded to at least three months of oral or parenteral methotrexate in combination with sulfasalazine and oxychloroquine sulphate (at maximum tolerated doses)
	or	$\circ$	Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with the maximum tolerated dose of cyclosporin
	or	$\bigcirc$	Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with intramuscular gold
and			Patient has tried and not responded to at least three months of therapy at the maximum tolerated dose of leflunomide alone or in combination with oral or parenteral methotrexate
and	or	0	Patient has persistent symptoms of poorly controlled and active disease in at least 20 swollen, tender joints
		0	Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip
and		0	Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application
	or	0	C-reactive protein levels not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months
and			
	or	$\bigcirc$	Rituximab to be used as an adjunct to methotrexate or leflunomide therapy
		$\bigcirc$	Patient is contraindicated to both methotrexate and leflunomide, requiring rituximab monotherapy to be used
and	$\supset$		mum of two 1,000 mg infusions of rituximab given two weeks apart

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.

ximab (M ITINUATIO) assessment requisites ( Presci Hospit  or  or  and	labthera)  N - rheu t required (tick boxe ribed by, tal.  At col At fro At 30 ph	Name:  NHI:  NI  NHI:  N	
Aximab (MATINUATION assessment requisites (MATINUATION ASSESSMENT	N – rheu t required (tick boxe ribed by, tal.  At col At fro At gray At gray Rituxima	matoid arthritis - re-treatment in 'partial responders' to rituximab lafter 4 months s where appropriate) or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ  4 months following the initial course of rituximab infusions the patient had between a 30% and 50% decrease in active joint unt from baseline and a clinically significant response to treatment in the opinion of the physician  4 months following the second course of rituximab infusions the patient had at least a 50% decrease in active joint count m baseline and a clinically significant response to treatment in the opinion of the physician  4 months following the third and subsequent courses of rituximab infusions, the patient demonstrates at least a continuing miprovement in active joint count from baseline and a clinically significant response to treatment in the opinion of the visician	
and and	N – rheu t required (tick boxe ribed by, tal.  At col At fro At 30 ph	matoid arthritis - re-treatment in 'partial responders' to rituximab after 4 months s where appropriate) or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ  4 months following the initial course of rituximab infusions the patient had between a 30% and 50% decrease in active joint unt from baseline and a clinically significant response to treatment in the opinion of the physician  4 months following the second course of rituximab infusions the patient had at least a 50% decrease in active joint count m baseline and a clinically significant response to treatment in the opinion of the physician  4 months following the third and subsequent courses of rituximab infusions, the patient demonstrates at least a continuing miprovement in active joint count from baseline and a clinically significant response to treatment in the opinion of the previous course of treatment in the opinion of the previous course of treatment in the opinion of the previous course of treatment in the opinion of the previous course of treatment in the opinion of the previous course of treatment in the opinion of the previous course of treatment in the opinion of the previous course of treatment in the opinion of the previous course of treatment in the opinion of the previous course of treatment in the opinion of the previous course of treatment in the opinion of the previous course of treatment in the opinion of the previous course of treatment in the opinion of the previous course of treatment in the opinion of the previous course of treatment in the opinion of treatment in the opinion of the previous course of treatment in the opinion of the previous course of treatment in the opinion of the previous course of treatment in the opinion of the previous course of treatment in the opinion of the previous course of treatment in the opinion of the previous course of treatment in the opinion of the previous course of treatment in the opinion of the previous course of treatment in	
assessment requisites ( Prescue Hospit  or  or  and  and	required (tick boxe) ribed by, tal.  At cool At fro  At ground At	after 4 months s where appropriate) or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ  4 months following the initial course of rituximab infusions the patient had between a 30% and 50% decrease in active joint unt from baseline and a clinically significant response to treatment in the opinion of the physician  4 months following the second course of rituximab infusions the patient had at least a 50% decrease in active joint count m baseline and a clinically significant response to treatment in the opinion of the physician  4 months following the third and subsequent courses of rituximab infusions, the patient demonstrates at least a continuing miprovement in active joint count from baseline and a clinically significant response to treatment in the opinion of the visician  b re-treatment not to be given within 6 months of the previous course of treatment	
Presci Hospit or or and	Citick boxed ribed by, tal.  At cool At from At 30 ph;  Rituxima	or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ  4 months following the initial course of rituximab infusions the patient had between a 30% and 50% decrease in active joint unt from baseline and a clinically significant response to treatment in the opinion of the physician  4 months following the second course of rituximab infusions the patient had at least a 50% decrease in active joint count m baseline and a clinically significant response to treatment in the opinion of the physician  4 months following the third and subsequent courses of rituximab infusions, the patient demonstrates at least a continuing minorovement in active joint count from baseline and a clinically significant response to treatment in the opinion of the previous course of treatment not to be given within 6 months of the previous course of treatment	
or or and one and	At cool At fro At sooph	4 months following the initial course of rituximab infusions the patient had between a 30% and 50% decrease in active joint unt from baseline and a clinically significant response to treatment in the opinion of the physician  4 months following the second course of rituximab infusions the patient had at least a 50% decrease in active joint count m baseline and a clinically significant response to treatment in the opinion of the physician  4 months following the third and subsequent courses of rituximab infusions, the patient demonstrates at least a continuing miprovement in active joint count from baseline and a clinically significant response to treatment in the opinion of the ysician  b re-treatment not to be given within 6 months of the previous course of treatment	
or or and on and	O At cor	4 months following the second course of rituximab infusions the patient had at least a 50% decrease in active joint count m baseline and a clinically significant response to treatment in the opinion of the physician  4 months following the third and subsequent courses of rituximab infusions, the patient demonstrates at least a continuing minimum in active joint count from baseline and a clinically significant response to treatment in the opinion of the ysician  b re-treatment not to be given within 6 months of the previous course of treatment	
and O and	O At fro At 30 ph	4 months following the second course of rituximab infusions the patient had at least a 50% decrease in active joint count m baseline and a clinically significant response to treatment in the opinion of the physician  4 months following the third and subsequent courses of rituximab infusions, the patient demonstrates at least a continuing minimum in active joint count from baseline and a clinically significant response to treatment in the opinion of the ysician  b re-treatment not to be given within 6 months of the previous course of treatment	
and O and	At 30 ph	m baseline and a clinically significant response to treatment in the opinion of the physician  4 months following the third and subsequent courses of rituximab infusions, the patient demonstrates at least a continuing % improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the ysician  b re-treatment not to be given within 6 months of the previous course of treatment	
and	30' ph:	% improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the ysician  b re-treatment not to be given within 6 months of the previous course of treatment	
and			
or	O Rit	uximab to be used as an adjunct to methotrexate or leflunomide therapy	
Or Or			
(	O Pa	tient is contraindicated to both methotrexate and leflunomide, requiring rituximab monotherapy to be used	
O	Maximur	n of two 1,000 mg infusions of rituximab given two weeks apart	
assessment	t required	matoid arthritis - re-treatment in 'responders' to rituximab after 4 months s where appropriate)	
O Presci Hospit		or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ	
or		4 months following the initial course of rituximab infusions the patient had at least a 50% decrease in active joint count from seline and a clinically significant response to treatment in the opinion of the physician	
S.	30	4 months following the second and subsequent courses of rituximab infusions, the patient demonstrates at least a continuing % improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the ysician	
and	Rituxima	b re-treatment not to be given within 6 months of the previous course of treatment	
or	O Rit	uximab to be used as an adjunct to methotrexate or leflunomide therapy	
	O Pa	tient is contraindicated to both methotrexate and leflunomide, requiring rituximab monotherapy to be used	
and O Maximum of two 1,000 mg infusions of rituximab given two weeks apart			

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#### RS1922 - Adalimumab (Humira - Alternative brand)

Arthritis - polyarticular course juvenile idiopathic - INITIATION	418
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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:						
Adal	imu	mak	o (Humira - Alternative brand)			
Re-a	sses equi:	smen sites Presc	Behcet's disease – severe t required after 6 months (tick boxes where appropriate) cribed by, or recommended by any relevant practitioner, or in acospital.	cordance with a protocol or guideline that has been endorsed by the Health		
		or		trol following a minimum of 4 weeks treatment with adalimumab esponse to a change in treatment regimen		
	and		Patient has received a maximum of 6 months treatment with A Patient has previously had a Special Authority approval for the	Humira brand of adalimumab for this indication		
			Adalimumab to be administered at doses no greater than 40 m  ON – Behcet's disease – severe t required after 6 months	ig every 14 days		
Prere	C	Preso NZ H	(tick boxes where appropriate)  bribed by, or recommended by any relevant practitioner, or in accospital.  The patient has had a good clinical response to treatment with Adalimumab to be administered at doses no greater than 40 m			
			Hidradenitis suppurativa t required after 6 months			
			(tick boxes where appropriate)			
and			cribed by, or recommended by a dermatologist or Practitioner of ideline that has been endorsed by the Health NZ Hospital.	n the recommendation of a dermatologist, or in accordance with a protocol		
	and and			mgevita		
		0	Adalimumab to be administered at doses no greater than 40 m	ng every 7 days. Fortnightly dosing has been considered		

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Signeg	 Date	

PRESCRIBER		PATIENT:		
Name:		Name:		
Ward:		NHI:		
Adalimumab (	Humira - Alternative brand) - continued			
Re-assessment re	- Hidradenitis suppurativa equired after 6 months ck boxes where appropriate)			
O Prescrib or guide	O Prescribed by, or recommended by a dermatologist or Practitioner on the recommendation of a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
and Th	the patient has a reduction in active lesions (e.g. inflammator the patient has a Dermatology Quality of Life Index improvem dalimumab is to be administered at doses no greater than 40			
Re-assessment re	oriasis - severe chronic plaque equired after 6 months ck boxes where appropriate)			
	ped by, or recommended by a dermatologist or Practitioner or eline that has been endorsed by the Health NZ Hospital.	n the recommendation of a dermatologist, or in accordance with a protocol		
or (		rol following a minimum of 4 weeks treatment with adalimumab sponse to a change in treatment regimen		
and	atient has received a maximum of 6 months treatment with A			
and Ac	dalimumab to be administered at doses no greater than 40 m	g every 14 days		

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Signed.	Date:	
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PRESCRI	BER		PATIENT:
Name:			Name:
Ward:			NHI:
Adalimu	ımab	(Hui	mira - Alternative brand) - continued
Re-asses	sites Preso	t requii (tick bo cribed b	soriasis - severe chronic plaque red after 6 months oxes where appropriate)  oy, or recommended by a dermatologist or Practitioner on the recommendation of a dermatologist, or in accordance with a protocol that has been endorsed by the Health NZ Hospital.
		and	O Patient had "whole body" severe chronic plaque psoriasis at the start of treatment
			Following each prior adalimumab treatment course the patient has a PASI score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-adalimumab treatment baseline value  Following each prior adalimumab treatment course the patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, when compared with the pre-treatment baseline value
	or		
		and	O Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment
			Following each prior adalimumab treatment course the patient has a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the treatment course baseline values  Following each prior adalimumab treatment course the patient has a reduction of 75% or more in the skin area
			affected, or sustained at this level, as compared to the pre-adalimumab treatment baseline value
and	O	Adalin	numab to be administered at doses no greater than 40 mg every 14 days
Re-asses	ssmen	t requi	rma gangrenosum red after 6 months exposes where appropriate)
and		ribed b	by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
		O	The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment
	or	0	Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen
and	and Patient has received a maximum of 6 months treatment with Amgevita		It has received a maximum of 6 months treatment with Amgevita
	0	Patien	t has previously had a Special Authority approval for the Humira brand of adalimumab for this indication
and	$\circ$	A max	ximum of 8 doses

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:		
Adalim	numab (Humira - Alternative brand) - continued			
Prerequent and	NUATION – Pyoderma gangrenosum essment required after 6 months uisites (tick boxes where appropriate)  Prescribed by, or recommended by a dermatologist, or in accordance Hospital.  The patient has demonstrated clinical improvement and continued  A maximum of 8 doses	with a protocol or guideline that has been endorsed by the Health NZ ues to require treatment		
Re-asse Prerequiand	or  Patient has developed symptoms of loss of disease control or months treatment with Amgevita and clinician attributes  Or  Patient has developed symptoms of loss of disease control or months treatment with Amgevita and clinician attributes	adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of a this loss of disease response to a change in treatment regimen ease destabilisation if there were to be a change to current treatment.  Humira brand of adalimumab for this indication		
Re-asse	NUATION – Crohn's disease - adult essment required after 6 months uisites (tick boxes where appropriate)  Prescribed by, or recommended by a gastroenterologist or Practitione protocol or guideline that has been endorsed by the Health NZ Hospit	er on the recommendation of a gastroenterologist, or in accordance with a tal.		
	O CDAI score has reduced by 100 points from the CDAI score or O CDAI score is 150 or less Or O The patient has demonstrated an adequate response to to the Adalimumab to be administered at doses no greater than 40 mg	reatment, but CDAI score cannot be assessed		

I confirm that the above details are correct:

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

### HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRES	CRII	BER		PATIENT:
Name	:		•••••	
Ward:				NHI:
Adal	imu	mak	Hu	mira - Alternative brand) - continued
Re-a	INITIATION – Crohn's disease - children Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a gastroen			ired after 6 months
and	and	or or	O O Patie	The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita  Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen  Patient has Crohn's and is considered to be at risk of disease destabilisation if there were to be a change to current treatment on the has previously had a Special Authority approval for the Humira brand of adalimumab for this indication mumab to be administered at doses no greater than 40 mg every 14 days
Re-a	ssess equis	smen sites Preso	t requ (tick t	rohn's disease - children ired after 6 months oxes where appropriate)  by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.
	and	or or	O O Adal	PCDAI score has reduced by 10 points from the PCDAI score when the patient was initiated on adalimumab PCDAI score is 15 or less The patient has demonstrated an adequate response to treatment, but PCDAI score cannot be assessed mumab to be administered at doses no greater than 40 mg every 14 days
INITIATION – Crohn's disease - fistulising Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance wi protocol or guideline that has been endorsed by the Health NZ Hospital.			ired after 6 months oxes where appropriate) by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a	
	and	$\circ$	O O Patie	The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita  Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen  Patient has Crohn's and is considered to be at risk of disease destabilisation if there were to be a change to current treatment of the previously had a Special Authority approval for the Humira brand of adalimumab for this indication
			Adal	mumab to be administered at doses no greater than 40 mg every 14 days

I confirm that the above details are correct:

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

PRESCRIBER				PATIENT:		
Name:						
Ward:				NHI:		
Adalimumab (Humira - Alternative brand) - continued						
Re-ass	sess	ment	requ	crohn's disease - fistulising ired after 6 months oxes where appropriate)		
O Prescribed by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accommendation of a gastroenterologist or protocol or guideline that has been endorsed by the Health NZ Hospital.			by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.			
		or	0	The number of open draining fistulae have decreased from baseline by at least 50%		
		J.	0	There has been a marked reduction in drainage of all fistula(e) from baseline as demonstrated by a reduction in the Fistula Assessment score, together with less induration and patient-reported pain		
•	and (	<b>O</b>	Adali	mumab to be administered at doses no greater than 40 mg every 14 days		
Re-ass	sess	ment	requ	r inflammation – chronic ired after 12 months oxes where appropriate)		
and			ribed ospita	by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health I.		
		or or	<ul><li>O</li><li>O</li><li>O</li></ul>	The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita  Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with Amgevita, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen  Patient has uveitis and is considered to be at risk of vision loss if they were to change treatment		
	and ( and (	$\overline{}$		nt has previously had a Special Authority approval for the Humira brand of adalimumab for this indication mumab to be administered at doses no greater than 40 mg every 14 days		
Re-ass	sess <b>quis</b> i	ment i <b>tes</b> (	requ tick b	Decular inflammation – chronic ired after 12 months oxes where appropriate)  by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health		
and			spita			
		or or	0	The patient has had a good clinical response following 12 weeks' initial treatment  Following each 12-month treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema)  Following each 12-month treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old		
	and (	C	Adali	mumab to be administered at doses no greater than 40 mg every 14 days		

PRES	SCRIE	BER			PATIENT:	
Name	e:				Name:	
Ward	:				NHI:	
Ada	limu	mak	o (Hu	ımira - Alternative brand) - continued		
Re-a	equis	smen sites	t requ (tick b	r inflammation – severe ired after 12 months oxes where appropriate)		
and			cribed lospita		cordance with a protocol or guideline that has been endorsed by the Health	
		or	0	and a maximum of 6 months treatment with Amgevita	rol following a minimum of 4 weeks treatment,	
		or	_		ician attributes this loss of disease response to a change in treatment	
			$\circ$	Patient has uveitis and is considered to be at risk of vision	n loss if they were to change treatment	
	and	$\circ$		nt has previously had a Special Authority approval for the mumab to be administered at doses no greater than 40 m		
Re-a	assess	smen	it requ	Ocular inflammation – severe ired after 12 months oxes where appropriate)		
			cribed lospita		cordance with a protocol or guideline that has been endorsed by the Health	
		or	0	The patient has had a good clinical response following 3	initial doses	
		or	0	Following each 12-month treatment period, the patient h. Uveitis Nomenclature (SUN) criteria < ½+ anterior cham resolution of uveitic cystoid macular oedema)	as had a sustained reduction in inflammation (Standardisation of ber or vitreous cells, absence of active vitreous or retinal lesions, or	
		J.	0	Following each 12-month treatment period, the patient had to < 10mg daily, or steroid drops less than twice daily if u	as a sustained steroid sparing effect, allowing reduction in prednisone inder 18 years old	
	and	nd O Adalimumab to be administered at doses no greater than 40 mg every 14 days				

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.

PRES	CRIBER PATIENT:	
Name	:	
Ward	NHI:	
Adal	mumab (Humira - Alternative brand) - continued	
Re-a	ATION – ankylosing spondylitis seessment required after 6 months equisites (tick boxes where appropriate)  Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment or Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita)  Patient has received a maximum of 6 months treatment with Amgevita  Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication  Adalimumab to be administered at doses no greater than 40 mg every 14 days	
Re-a	TINUATION – ankylosing spondylitis seessment required after 6 months equisites (tick boxes where appropriate)  Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10 point scale, or an improvement in BASDAI of 50%, whichever is less  and  Adalimumab to be administered at doses no greater than 40 mg every 14 days	
INITIATION – Arthritis – oligoarticular course juvenile idiopathic Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has by the Health NZ Hospital.  and		
	Or The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment O Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen  Patient has received a maximum of 6 months treatment with Amgevita  Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication	

I confirm that the above details are correct:

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

PRESCRIBER	PATIENT:				
Name:	Name:				
Ward:	NHI:				
Adalimumab (Humira - Alternative brand) - continued					
CONTINUATION – Arthritis – oligoarticular course juvenile idiopathic Re-assessment required after 6 months	`				
Prerequisites (tick box where appropriate)					
Prescribed by, or recommended by a named specialist or rheumatole by the Health NZ Hospital.	ogist, or in accordance with a protocol or guideline that has been endorsed				
	nt in active joint count and continued improvement in physician's global				
INITIATION – Arthritis - polyarticular course juvenile idiopathic Re-assessment required after 6 months					
Prerequisites (tick boxes where appropriate)					
O Prescribed by, or recommended by a named specialist or rheumatolo by the Health NZ Hospital.	ogist, or in accordance with a protocol or guideline that has been endorsed				
O The patient has experienced intolerable side effects from or	n adalimumab (Amgevita) following a minimum of 4 weeks treatment				
	trol following a minimum of 4 weeks treatment with adalimumab esponse to a change in treatment regimen				
Patient has received a maximum of 6 months treatment with A and Patient has previously had a Special Authority approval for the					
CONTINUATION – Arthritis - polyarticular course juvenile idiopathic Re-assessment required after 6 months Prerequisites (tick box where appropriate)					
by the Health NZ Hospital.	ogist, or in accordance with a protocol or guideline that has been endorsed				
For patients that demonstrate at least a continuing 30% improvement assessment from baseline	nt in active joint count and continued improvement in physician's global				
INITIATION – Arthritis - psoriatic Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	Re-assessment required after 6 months				
O Prescribed by, or recommended by a named specialist or rheumatolo by the Health NZ Hospital.	ogist, or in accordance with a protocol or guideline that has been endorsed				
	n adalimumab (Amgevita) following a minimum of 4 weeks treatment				
Patient has developed symptoms of loss of disease cont (Amgevita) and clinician attributes this loss of disease re	trol following a minimum of 4 weeks treatment with adalimumab esponse to a change in treatment regimen				
Patient has received a maximum of 6 months treatment with A	mgevita				
Patient has previously had a Special Authority approval for the	Humira brand of adalimumab for this indication				
Adalimumab to be administered at doses no greater than 40 m	ng every 14 days				

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.

PRES	CRIBER	ER PATIENT:	
Name	e:	Name:	
Ward	:	NHI:	
Adal	imumat	nab (Humira - Alternative brand) - continued	
Re-a	ssessmen equisites Preso	TION – Arthritis - psoriatic nent required after 6 months es (tick boxes where appropriate)  rescribed by, or recommended by a named specialist or rheumatologist, or in accordar the Health NZ Hospital.  The patient demonstrates at least a continuing 30% improvement in active joint or response to prior adalimumab treatment in the opinion of the treating physician  Adalimumab to be administered at doses no greater than 40 mg every 14 days	
INITIATION – Arthritis – rheumatoid Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			ation of a rheumatologist, or in accordance with a
	and or	Patient has developed symptoms of loss of disease control following a min (Amgevita) and clinician attributes this loss of disease response to a change Patient has received a maximum of 6 months treatment with Amgevita Patient has previously had a Special Authority approval for the Humira brand of a Adalimumab to be administered at doses no greater than 40 mg every 14 or	imum of 4 weeks treatment with adalimumab ge in treatment regimen adalimumab for this indication days
		an adequate response	
CONTINUATION – Arthritis – rheumatoid Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
and	and	The patient demonstrates at least a continuing 30% improvement in active joint or response to prior adalimumab treatment in the opinion of the treating physician	count from baseline and a clinically significant
		O Adalimumab to be administered at doses no greater than 40 mg every 14 d	days
	or	O Patient cannot take concomitant methotrexate and requires doses of adalir an adequate response	numab higher than 40 mg every 14 days to maintain

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:				
Adalimumab (Humira - Alternative brand) - continued					
INITIATION – Still's disease – adult-onset (AOSD) Re-assessment required after 6 months					
Prerequisites (tick boxes where appropriate)					
Prescribed by, or recommended by a rheumatologist or Practitioner protocol or guideline that has been endorsed by the Health NZ Hosp	on the recommendation of a rheumatologist, or in accordance with a bital.				
O The patient has experienced intolerable side effects from	m adalimumab (Amgevita) following a minimum of 4 weeks treatment				
Patient has developed symptoms of loss of disease con (Amgevita) and clinician attributes this loss of disease re	trol following a minimum of 4 weeks treatment with adalimumab esponse to a change in treatment regimen				
and Patient has received a maximum of 6 months treatment with A and	amgevita				
Patient has previously had a Special Authority approval for the	e Humira brand of adalimumab for this indication				
CONTINUATION – Still's disease – adult-onset (AOSD) Re-assessment required after 6 months Prerequisites (tick box where appropriate)					
Prescribed by, or recommended by a rheumatologist or Practitioner protocol or guideline that has been endorsed by the Health NZ Hosp	on the recommendation of a rheumatologist, or in accordance with a pital.				
The patient has demonstrated a sustained improvement in inflamma	atory markers and functional status				
The patient has demonstrated a sustained improvement in inflamma	atory markers and functional status				

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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.

PRES	SCR	IBER		PATIENT:		
Name	Name:			Name:		
Ward:	:			NHI:		
Abci	Abciximab					
INITIATION Prerequisites (tick boxes where appropriate)						
		0	For use in patients with acute coronary syndromes undergoing	g percutaneous coronary intervention		
	or	0	For use in patients undergoing intra-cranial intervention			

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.

PRESCRI	BER	PATIENT:
Name:		
Ward:		NHI:
Nivolum	ab	
Prerequis	sment r <b>sites</b> (ti	equired after 4 months ck boxes where appropriate)  ped by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and	О р О в	atient has metastatic or unresectable melanoma (excluding uveal) stage III or IV aseline measurement of overall tumour burden is documented clinically and radiologically
and	От	he patient has ECOG performance score of 0-2
	or (	Patient has not received funded pembrolizumab
		Patient has received an initial Special Authority approval for pembrolizumab and has discontinued pembrolizumab within 12 weeks of starting treatment due to intolerance  and  The cancer did not progress while the patient was on pembrolizumab
CONTINU	0 0	ocumentation confirming that the patient has been informed and acknowledges that funded treatment with nivolumab will not be ontinued if their disease progresses  — less than 24 months on treatment
		equired after 4 months ck boxes where appropriate)
	Prescril Hospita	ped by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ il.
		Patient's disease has had a complete response to treatment  Patient's disease has had a partial response to treatment  Patient has stable disease
	and (and	Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period  The treatment remains clinically appropriate and the patient is benefitting from the treatment
or	and (and	Patient has previously discontinued treatment with nivolumab for reasons other than severe toxicity or disease progression  Patient has signs of disease progression  Disease has not progressed during previous treatment with nivolumab
		Discuss has not progressed during previous treatment with hivolulian

Cianad.	Doto.	
Siurieu.	 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:
Nivo	luma	<b>ab</b> - <i>c</i>	continu	ed
Re-a	ssess <b>equis</b>	rescri	require ick box ibed by al.	re than 24 months on treatment dafter 4 months es where appropriate)  r, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
	Patient has been on treatment for more than 24 months  Or Patient's disease has had a complete response to treatment Or Patient has stable disease  and Response to treatment in target lesions has been determined by comparable radiologic or clinical assessment following the most recent treatment period  The treatment remains clinically appropriate and the patient is benefitting from the treatment  Or  Patient has previously discontinued treatment with nivolumab for reasons other than severe toxicity or disease progression  and Patient has signs of disease progression  Disease has not progressed during previous treatment with nivolumab			
				ell carcinoma
				d after 4 months es where appropriate)
and	. a		ance w	r, or recommended by a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in vith a protocol or guideline that has been endorsed by the Health NZ Hospital.  is currently on treatment with nivolumab and met all remaining criteria prior to commencing treatment
	or		$\overline{}$	atient has metastatic renal-cell carcinoma
		and (and (and (and	О т О р О р	atient has metastatic renal-cell carcinoma  he disease is of predominant clear-cell histology  atient has an ECOG performance score of 0-2  atient has documented disease progression following one or two previous regimens of antiangiogenic therapy  livolumab is to be used as monotherapy at a maximum dose of 240 mg every 2 weeks (or equivalent) and discontinued at isease progression
				F F

Cianad.	Doto.	
Siurieu.	 Date.	

PRES	CRIB	ER		PATIENT:
Name	e:			Name:
Ward:				NHI:
Nivo	luma	ab -	- continued	
Re-a	ssess <b>equis</b> i	men ites Presc	ON - Renal cell carcinoma  nt required after 4 months  (tick boxes where appropriate)  cribed by, or recommended by any relevant practitioner, or in accompleted.	ordance with a protocol or guideline that has been endorsed by the Health
		or or	O Patient's disease has had a complete response to treatment O Patient's disease has had a partial response to treatment O Patient has stable disease	
	and ( and	) )	No evidence of disease progression  Nivolumab is to be used as monotherapy at a maximum dose o progression	f 240 mg every 2 weeks (or equivalent) and discontinued at disease

I confirm that the above details are correct:	
Signed:	Date:

#### RS2056 - Pembrolizumab

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	MSI-H/dMMR advanced colorectal cancer - INITIATION	432
	MSI-H/dMMR advanced colorectal cancer - CONTINUATION	433
	Urothelial carcinoma - INITIATION	433
	Urothelial carcinoma - CONTINUATION	433
	Breast cancer, advanced - INITIATION	430
	Breast cancer, advanced - CONTINUATION	
	Head and neck squamous cell carcinoma - INITIATION	431
	Head and neck squamous cell carcinoma - CONTINUATION	432
	Non-small cell lung cancer first-line combination therapy - INITIATION	
	Non-small cell lung cancer first-line combination therapy - CONTINUATION	430
	Non-small cell lung cancer first-line monotherapy - INITIATION	428
	Non-small cell lung cancer first-line monotherapy - CONTINUATION	429
	Relapsed/refractory Hodgkin lymphoma - INITIATION	434
	Relapsed/refractory Hodgkin lymphoma - CONTINUATION	434
	Unresectable or metastatic melanoma - INITIATION	426
	Unresectable or metastatic melanoma, less than 24 months on treatment - CONTINUATION	426
	Unresectable or metastatic melanoma, more than 24 months on treatment - CONTINUATION	427
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I confirm that the above details are correct:

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

### HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

SCRIBER	PATIENT:
ie:	
d:	NHI:
nbrolizuı	mab
assessmer	unresectable or metastatic melanoma at required after 4 months (tick boxes where appropriate)
Preso	cribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health Nital.
and	Patient has metastatic or unresectable melanoma (excluding uveal) stage III or IV
and	Baseline measurement of overall tumour burden is documented clinically and radiologically
and	The patient has ECOG performance score of 0-2
or	O Patient has not received funded nivolumab
	O Patient has received an initial Special Authority approval for nivolumab and has discontinued nivolumab within 12 weeks of starting treatment due to intolerance
	O The cancer did not progress while the patient was on nivolumab
and	
and	Documentation confirming that the patient has been informed and acknowledges that funded treatment with pembrolizumab will not be continued if their disease progresses
NTINUATIO assessmer	continued if their disease progresses  ON – unresectable or metastatic melanoma, less than 24 months on treatment at required after 4 months
NTINUATIO assessmer requisites	continued if their disease progresses  ON – unresectable or metastatic melanoma, less than 24 months on treatment it required after 4 months (tick boxes where appropriate)  cribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health
NTINUATIO assessmer requisites Preso Hosp	ON – unresectable or metastatic melanoma, less than 24 months on treatment at required after 4 months (tick boxes where appropriate)  cribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health ital.
NTINUATIO assessmer requisites Preso Hosp	ON – unresectable or metastatic melanoma, less than 24 months on treatment at required after 4 months (tick boxes where appropriate)  Cribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health ital.  O Patient's disease has had a complete response to treatment or
NTINUATIO assessmer requisites Preso Hosp	ON – unresectable or metastatic melanoma, less than 24 months on treatment at required after 4 months (tick boxes where appropriate)  Cribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health itial.  O Patient's disease has had a complete response to treatment
NTINUATIO assessmer requisites Preso Hosp	ON – unresectable or metastatic melanoma, less than 24 months on treatment at required after 4 months (tick boxes where appropriate)  Cribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health itial.  O Patient's disease has had a complete response to treatment  O Patient's disease has had a partial response to treatment
NTINUATIO assessmer requisites Preso Hosp	ON – unresectable or metastatic melanoma, less than 24 months on treatment it required after 4 months (tick boxes where appropriate)  cribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health ital.  O Patient's disease has had a complete response to treatment  or O Patient's disease has had a partial response to treatment  O Patient has stable disease  Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent
NTINUATIO assessmer requisites Preso Hosp	ON – unresectable or metastatic melanoma, less than 24 months on treatment at required after 4 months (tick boxes where appropriate)  Oribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health ital.  Original Patient's disease has had a complete response to treatment or Original Patient's disease has had a partial response to treatment or Original Patient's disease has had a partial response to treatment or Original Patient has stable disease  Original Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period
NTINUATIO assessmer requisites Press Hosp	ON – unresectable or metastatic melanoma, less than 24 months on treatment at required after 4 months (tick boxes where appropriate)  Oribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health ital.  O Patient's disease has had a complete response to treatment or O Patient's disease has had a partial response to treatment O Patient has stable disease  Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period
NTINUATIO assessmer requisites Press Hosp	ON – unresectable or metastatic melanoma, less than 24 months on treatment it required after 4 months (tick boxes where appropriate)  Or Patient's disease has had a complete response to treatment or Patient's disease has had a partial response to treatment or Patient has stable disease  Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period  The treatment remains clinically appropriate and the patient is benefitting from the treatment  Patient has previously discontinued treatment with pembrolizumab for reasons other than severe toxicity or disease progression
NTINUATION assessment requisites  Present Hospital and	continued if their disease progresses    N - unresectable or metastatic melanoma, less than 24 months on treatment the required after 4 months (tick boxes where appropriate)   Or patient's disease has had a complete response to treatment

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pembrolizumab - continued	
CONTINUATION – unresectable or metastatic melanoma, more than 24 in Re-assessment required after 4 months  Prerequisites (tick boxes where appropriate)	months on treatment
	rdance with a protocol or guideline that has been endorsed by the Health NZ
Patient has been on treatment for more than 24 months and	
Patient's disease has had a complete response or Patient's disease has had a partial response or Patient has stable disease	
Response to treatment in target lesions has been the most recent treatment period and  The treatment remains clinically appropriate and	the patient is benefitting from the treatment
Patient has previously discontinued treatment wit progression  and Patient has signs of disease progression and	h pembrolizumab for reasons other than severe toxicity or disease
O Disease has not progressed during previous trea	tment with pembrolizumab

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- 3	Ziuneu.	Date:	
•	Jigi ica.	 Duic.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pembrolizumab - continued	
INITIATION – non-small cell lung cancer first-line monotherapy Re-assessment required after 4 months  Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a medical oncologist or any relevant	vant practitioner on the recommendation of a medical oncologist, or in
accordance with a protocol or guideline that has been endorsed by t	
Pembrolizumab to be used as monotherapy  and  There is documentation confirming the disease expressor validated test unless not possible to ascertain  There is documentation confirming the disease expressor validated test unless not possible to ascertain  There is documentation confirming the disease expressor by a validated test unless not possible to ascertain	tative setting  the checkpoint inhibitor for NSCLC  tion confirming that the disease does not express activating mutations of  the PD-L1 at a level greater than or equal to 50% as determined by a  the presses PD-L1 at a level greater than or equal to 1% as determined
and O Patient has an ECOG 0-2 and O Pembrolizumab to be used at a maximum dose of 200 mg ever and O Baseline measurement of overall tumour burden is documented.	

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Signed.	Date:	
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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:			
Ward:	<i>y</i> ard:NHI:		
Pembrolizu	mab - continued		
Prerequisites  Pres	ON – non-small cell lung cancer first-line monotherapy Intrequired after 4 months (tick boxes where appropriate)  cribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or introduce with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
or	O Patient's disease has had a complete response to treatment O Patient's disease has had a partial response to treatment O Patient has stable disease		
and and and and and and and	Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period  No evidence of disease progression  The treatment remains clinically appropriate and patient is benefitting from treatment  Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent)  Treatment with pembrolizumab to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks)		
Prerequisites  Pres	non-small cell lung cancer first-line combination therapy at required after 4 months (tick boxes where appropriate)  cribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in redance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
and	Patient has locally advanced or metastatic, unresectable, non-small cell lung cancer  The patient has not had chemotherapy for their disease in the palliative setting  Patient has not received prior funded treatment with an immune checkpoint inhibitor for NSCLC  For patients with non-squamous histology there is documentation confirming that the disease does not express activating mutations of EGFR or ALK tyrosine kinase unless not possible to ascertain  Pembrolizumab to be used in combination with platinum-based chemotherapy  Patient has an ECOG 0-2  Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent) for a maximum of 16 weeks  Baseline measurement of overall tumour burden is documented clinically and radiologically		

I confirm that the above details are correct:

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

I confirm that the above details are correct:

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

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pembrolizumab - continued	
CONTINUATION – non-small cell lung cancer first-line combination thera Re-assessment required after 4 months  Prerequisites (tick boxes where appropriate)	ру
O Prescribed by, or recommended by a medical oncologist or any relevance accordance with a protocol or guideline that has been endorsed by tand	vant practitioner on the recommendation of a medical oncologist, or in he Health NZ Hospital.
Patient's disease has had a complete response to treatmen  Patient's disease has had a partial response to treatmen  Patient has stable disease	
Response to treatment in target lesions has been determined treatment period  and  No evidence of disease progression  and  The treatment remains clinically appropriate and patient is ber and  Pembrolizumab to be used at a maximum dose of 200 mg ever and	
INITIATION – breast cancer, advanced Re-assessment required after 6 months  Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a relevant specialist or any relevance accordance with a protocol or guideline that has been endorsed by the and  Patient is currently on treatment with pembrolizumab and met	he Health NZ Hospital.
Patient has recurrent or de novo unresectable, including or  Patient has recurrent or de novo unresectable, including or ISH+ [including FISH or other technology]  and Patient is treated with palliative intent and Patient's cancer has confirmed PD-L1 Combined Positive and Patient has received no prior systemic therapy in the palliand Patient has an ECOG score of 0–2 and Pembrolizumab is to be used in combination with chemicand Baseline measurement of overall tumour burden is document.	perable locally advanced triple-negative breast cancer (that does not g FISH or other technology]) negative breast cancer (that does not express ER, PR or HER2 IHC3+  e Score (CPS) is greater than or equal to 10  liative setting  otherapy mented clinically and radiologically
Pembrolizumab is to be used at a maximum dose of 200	mg every three weeks (or equivalent) for a maximum of 16 weeks

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:	
Ward:	NHI:
Pembrolizu	mab - continued
CONTINUATION Re-assessmer Prerequisites  O Pres	ON – breast cancer, advanced it required after 6 months (tick boxes where appropriate)  cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health lospital.  O Patient's disease has had a complete response to treatment O Patient's disease has had a partial response to treatment O Patient has stable disease  No evidence of disease progression  Response to treatment in target lesions has been determined by a comparable radiologic assessment following the most recent treatment period  Pembrolizumab is to be used at a maximum dose of 200 mg every three weeks (or equivalent)
Re-assessmer Prerequisites  Pres	Treatment with pembrolizumab is to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks)  head and neck squamous cell carcinoma at required after 4 months (tick boxes where appropriate)  cribed by, or recommended by a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in redance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
and O or an an an an	Patient is currently on treatment with pembrolizumab and met all remaining criteria prior to commencing treatment  Patient has recurrent or metastatic head and neck squamous cell carcinoma of mucosal origin (excluding nasopharyngeal carcinoma) that is incurable by local therapies  Patient has not received prior systemic therapy in the recurrent or metastatic setting  Patient has a positive PD-L1 combined positive score (CPS) of greater than or equal to 1  Patient has an ECOG performance score of 0-2  Pembrolizumab to be used in combination with platinum-based chemotherapy  Pembrolizumab to be used as monotherapy

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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 PATIENTS			PATIENT:
Name:			
Ward	:		NHI:
Pem	broli	zur	mab - continued
CON Re-a	TINU/ ssess equisi	ATIO men ites	ON – head and neck squamous cell carcinoma nt required after 4 months (itick boxes where appropriate)  cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health Hospital.  O Patient's disease has had a complete response to treatment  O Patient's disease has had a partial response to treatment
	(	C	Treatment with pembrolizumab is to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks)
Re-a	ssess equisi	men i <b>tes</b> Presc	MSI-H/dMMR advanced colorectal cancer not required after 4 months (tick boxes where appropriate)  Acribed by, or recommended by a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in ordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
and	or (	C	Patient is currently on treatment with pembrolizumab and met all remaining criteria prior to commencing treatment
		and and and and	Patient is treated with palliative intent  Patient has not previously received funded treatment with pembrolizumab  Patient has an ECOG performance score of 0-2  Baseline measurement of overall tumour burden is documented clinically and radiologically

I confirm that the above details are correct:

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

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRES	CRIBER PATIENT:
Name:	Name:
Ward:	NHI:
Pemb	prolizumab - continued
CONT Re-ass Prere	TINUATION – MSI-H/dMMR advanced colorectal cancer sessment required after 4 months quisites (tick boxes where appropriate)  Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  No evidence of disease progression  Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent)  and  Treatment with pembrolizumab is to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks)
Re-as	ATION – Urothelial carcinoma seessment required after 4 months quisites (tick boxes where appropriate)
and	Prescribed by, or recommended by a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	O Patient is currently on treatment with pembrolizumab and met all remaining criteria prior to commencing treatment or
	Patient has inoperable locally advanced (T4) or metastatic urothelial carcinoma  Patient has an ECOG performance score of 0-2  and Patient has documented disease progression following treatment with chemotherapy  and Pembrolizumab to be used as monotherapy at a maximum dose of 200 mg every three weeks (or equivalent) for a maximum of 16 weeks
Re-as Prere	ININATION – Urothelial carcinoma sessment required after 4 months quisites (tick boxes where appropriate)  Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Patient's disease has had a complete response to treatment or Patient's disease has had a partial response to treatment or Patient has stable disease  And No evidence of disease progression and Pembrolizumab is to be used as monotherapy at a maximum dose of 200 mg every three weeks (or equivalent)
	and  Treatment with pembrolizumab is to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks)

PRES	CRIBE	ER	PATIENT:
Name	):		Name:
Ward:			NHI:
Pem	broliz	zumab - continued	
INITI Re-a	ATION ssessn equisit	- relapsed/refractory Hodgkin lymphoma nent required after 4 months les (tick boxes where appropriate)	
		Patient has relapsed/refractory Hodgkin lym and Patient is ineligible for autologous stem cell or	rphoma after two or more lines of chemotherapy transplant a and has previously undergone an autologous stem cell transplant
Re-a	ssessn <b>equisit</b> Pr	TION - relapsed/refractory Hodgkin lymphoma nent required after 6 months res (tick boxes where appropriate) rescribed by, or recommended by any relevant practitioner, or in ac Z Hospital.	ecordance with a protocol or guideline that has been endorsed by the Health
	and	Patient has received a partial or complete response to pembro  Treatment with pembrolizumab is to cease after a total duratic every 3 weeks)	on of 24 months from commencement (or equivalent of 35 cycles dosed

I confirm that the above details are correct:

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PRESCRIBER		R	PATIENT:
Name:			
Ward:			NHI:
Durva	luma	ab	
Re-as	sessm	nent	on-small cell lung cancer required after 4 months tick boxes where appropriate)
		or	O Patient has histologically or cytologically documented stage III, locally advanced, unresectable non-small cell lung cancer (NSCLC) O Patient has histologically or cytologically documented stage IIb (T1N2a only), locally advanced, unresectable non-small cell lung cancer (NSCLC)
:	and and and and and and	O O O O O O O O O O O O O O O O O O O	Patient has received two or more cycles of platinum-based chemotherapy concurrently with definitive radiation therapy  Patient has no disease progression following the second or subsequent cycle of platinum-based chemotherapy with definitive radiation therapy treatment  Patient has a ECOG performance status of 0 or 1  Patient has completed last radiation dose within 8 weeks of starting treatment with durvalumab  Patient must not have received prior PD-1 or PD-L1 inhibitor therapy for this condition  O Durvalumab is to be used at a maximum dose of no greater than 10 mg/kg every 2 weeks  O Durvalumab is to be used at a flat dose of 1500 mg every 4 weeks  Treatment with durvalumab to cease upon signs of disease progression
Re-ass Prerec	sessm quisite and	or	N – Non-small cell lung cancer required after 4 months tick boxes where appropriate)  The treatment remains clinically appropriate and the patient is benefitting from treatment  Durvalumab is to be used at a maximum dose of no greater than 10 mg/kg every 2 weeks  Durvalumab is to be used at a flat dose of 1500 mg every 4 weeks  Treatment with durvalumab to cease upon signs of disease progression
		ر 	Total continuous treatment duration must not exceed 12 months

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.

PRESCRIBE	R PATIENT:
Name:	
Ward:	NHI:
Atezolizun	nab
Prerequisite  O Pre	ent required after 4 months es (tick boxes where appropriate) escribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or incordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Patient has locally advanced or metastatic non-small cell lung cancer
and and and and and	Patient has not received prior funded treatment with an immune checkpoint inhibitor for NSCLC  For patients with non-squamous histology there is documentation confirming that the disease does not express activating mutations of EGFR or ALK tyrosine kinase unless not possible to ascertain  Patient has an ECOG 0-2  Patient has documented disease progression following treatment with at least two cycles of platinum-based chemotherapy  Atezolizumab is to be used as monotherapy at a dose of 1200 mg every three weeks (or equivalent) for a maximum of 16 weeks  Baseline measurement of overall tumour burden is documented clinically and radiologically
Prerequisite	ent required after 4 months es (tick boxes where appropriate) escribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in cordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	Patient's disease has had a complete response to treatment  Patient's disease has had a partial response to treatment  Patient has stable disease
and and and	Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period  No evidence of disease progression  The treatment remains clinically appropriate and patient is benefitting from treatment  Atezolizumab to be used at a maximum dose of 1200 mg every three weeks (or equivalent)
and	Treatment with atezolizumab to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks)

I confirm that the above details are correct:

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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:
Everolimus	
INITIATION Re-assessment required after 3 months Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a neurologist or oncologist, or in Health NZ Hospital.  and O Patient has tuberous sclerosis and O Patient has progressively enlarging sub-ependymal giant cell	astrocytomas (SEGAs) that require treatment
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a neurologist or oncologist, or in Health NZ Hospital.  and  O Documented evidence of SEGA reduction or stabilisation by Nand  The treatment remains appropriate and the patient is benefiting and  Everolimus to be discontinued at progression of SEGAs	
INITIATION – renal cell carcinoma Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)  The patient has metastatic renal cell carcinoma and The disease is of predominant clear-cell histology and The patient has documented disease progression follow and The patient has an ECOG performance status of 0-2 and Everolimus is to be used in combination with lenvatinib  or  Patient has received funded treatment with nivolumab for and Patient has experienced treatment limiting toxicity from and Everolimus is to be used in combination with lenvatinib and  Everolimus is to be used in combination with lenvatinib	for the second line treatment of metastatic renal cell carcinoma treatment with nivolumab
CONTINUATION – renal cell carcinoma Re-assessment required after 4 months Prerequisites (tick box where appropriate)  There is no evidence of disease progression	

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

I confirm that the above details are correct:

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

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Sirolimus	
INITIATION  Prerequisites (tick box where appropriate)  Or For rescue therapy for an organ transplant recipient  Note: Rescue therapy defined as unresponsive to calcineurin inh	nibitor treatment as defined by refractory rejection; or intolerant to calcineurin inhibitor
treatment due to any of the following:	
GFR < 30 ml/min; or	
Rapidly progressive transplant vasculopathy; or	
Rapidly progressive obstructive bronchiolitis; or	
HUS or TTP; or	
Leukoencepthalopathy; or	
Significant malignant disease	
INITIATION – severe non-malignant lymphovascular malform Re-assessment required after 6 months  Prerequisites (tick boxes where appropriate)	
Patient has severe non-malignant lymphovascula and	r malformation*
or Malformations are not adequately controlled	
or	nd sclerotherapy and surgery are not considered clinically appropriate
O Sirolimus is to be used to reduce malformation	tion prior to consideration of surgery
Patient is being treated by a specialist lymphovas and Patient has measurable disease as defined by Ri	
CONTINUATION – severe non-malignant lymphovascular ma Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	Iformations*
according to RECIST version 1.1 (see Note	e response or a partial response to treatment, or patient has stable disease e) ed clinically and disease response to treatment has been clearly documents in
and  No evidence of progressive disease and	
O The treatment remains clinically appropriate and	the patient is benefitting from the treatment
Note: Describes a second of discrete manners to be seen	sed according to the Response Evaluation Criteria in Solid Tumours (RECIST) version

I confirm that the above details are correct:

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

PRESCRIBER		PATIENT:
Name:		Name:
Nard:		NHI:
Sirolimus - co	ontinued	
Re-assessment Prerequisites (t  Prescri Health and  and	enal angiomyolipoma(s) associated with tuberous sclerosist required after 6 months tick boxes where appropriate) ribed by, or recommended by a nephrologist or urologist, or in an NZ Hospital.  Patient has tuberous sclerosis complex*  Evidence of renal angiomyolipoma(s) measuring 3 cm or greater	accordance with a protocol or guideline that has been endorsed by the
Re-assessment	N – renal angiomyolipoma(s) associated with tuberous sclorequired after 12 months tick boxes where appropriate)	erosis complex*
and and and	Documented evidence of renal angiomyolipoma reduction or st Demonstrated stabilisation or improvement in renal function The patient has not experienced angiomyolipoma haemorrhage The treatment remains appropriate and the patient is benefitting as marked with * are unapproved indications	e or significant adverse effects to sirolimus treatment
Re-assessment Prerequisites (t Prescri Hospita		ith a protocol or guideline that has been endorsed by the Health NZ
and and		·
or		atient has experienced unacceptable side effects from, optimal m valproate, topiramate, levetiracetam, carbamazepine, lamotrigine,
and F	Seizures have a significant impact on quality of life  Patient has been assessed and surgery is considered inapprophenefit from mTOR inhibitor treatment prior to surgery	oriate for this patient, or the patient has been assessed and would
	childbearing potential are not required to trial phenytoin sodium sodium valproate.	n, sodium valproate, and topiramate. Those who can father children are not

#### Form RS1991 January 2025

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:
Sirolimus - continued	
CONTINUATION – refractory seizures associated with tuberous sclerosis Re-assessment required after 12 months  Prerequisites (tick box where appropriate)	s complex*
Prescribed by, or recommended by a neurologist, or in accordance with Hospital.	with a protocol or guideline that has been endorsed by the Health NZ
O Demonstrated significant and sustained improvement in seizure rate quality of life compared with baseline prior to starting sirolimus treat Note: Indications marked with * are unapproved indications	e (e.g. 50% reduction in seizure frequency) or severity and/or patient ment

PATIENT:
Name:
NHI:

PRES	PRESCRIBER PATIENT:			
Name	lame:			
Ward	:	NHI:		
Upa	daci	tinib		
INIT	INITIATION – Rheumatoid Arthritis (patients previously treated with adalimumab or etanercept) Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  The patient has had an initial Special Authority approval for adalimumab and/or etanercept for rheumatoid arthritis  The patient has experienced intolerable side effects from adalimumab and/or etanercept or The patient has received insufficient benefit from at least a three-month trial of adalimumab and/or etanercept such that they do not meet the renewal criteria for rheumatoid arthritis  The patient is seronegative for both anti-cyclic citrullinated peptide (CCP) antibodies and rheumatoid factor  The patient has been started on rituximab for rheumatoid arthritis in a Health NZ Hospital  The patient has experienced intolerable side effects from rituximab  The patient has experienced intolerable side effects from rituximab  At four months following the initial course of rituximab the patient has received insufficient benefit such that they do not meet the renewal criteria for rheumatoid arthritis			
Re-a	CONTINUATION – Rheumatoid Arthritis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)			
		Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
	or	O Following 6 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician		
On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count a clinically significant response to treatment in the opinion of the physician		On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician		

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Baricitinib	
INITIATION – moderate to severe COVID-19* Re-assessment required after 14 days Prerequisites (tick boxes where appropriate)	
Patient has confirmed (or probable) COVID-19*  and Oxygen saturation of < 92% on room air, or requiring supplem	ental oxygen
Patient is receiving adjunct systemic corticosteroids, or system  and  Baricitinib is to be administered at doses no greater than 4 mg	
Baricitinib is not to be administered in combination with tocilize Note: Indications marked with * are unapproved indications.	umab

#### **Respiratory System and Allergies**



PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Icatibant	
endorsed by the Health NZ Hospital.	
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate)  The treatment remains appropriate and the patient is benefiting from	n treatment

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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.

PRES	SCRI	BER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Adre	enal	ine		
1			anaphylaxis (tick boxes where appropriate)	
	O Patient has experienced a previous anaphylactic reaction which has resulted in presentation to a hospital or emergency department			
	or	0	Patient has been assessed to be at significant risk of anaphyla	axis by a relevant practitioner

PRES	SCRIBER		PATIENT:
Name	e:		Name:
Ward	:		NHI:
Bee	venom		
	IATION equisites	(tick boxes where appropriate)	
	and	RAST or skin test positive	
		Patient has had severe generalised reaction to the sensitising	agent

PRES	SCRIBER	PATIENT:
Name	e:	Name:
Ward	:	NHI:
Pape	er wasp venom	
	IATION requisites (tick boxes where appropriate)	
	RAST or skin test positive	
	O Patient has had severe generalised reaction to the sensitising	agent

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Signed.	Date:	
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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Yellow jacket wasp venom	
INITIATION Prerequisites (tick boxes where appropriate)	
RAST or skin test positive	
Patient has had severe generalised reaction to the sensitising	agent

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Long-acting muscarinic antagonists with long-acting beta-	adrenoceptor agonists
INITIATION Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)  Patient has been stabilised on a long acting muscarinic antage and The prescriber considers that the patient would receive addition	
CONTINUATION Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)	
Patient is compliant with the medication and Patient has experienced improved COPD symptom control (pr	escriber determined)

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Oigilica.	 Duic.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Fluticasone fu	uroate with umeclidinium and vilanterol
INITIATION Prerequisites (ti	ick boxes where appropriate)
	Patient has a diagnosis of COPD confirmed by spirometry or spirometry has been attempted and technically acceptable results are not possible
or	Patient is currently receiving an inhaled corticosteroid with long acting beta-2 agonist (ICS/LABA) or a long acting muscarinic antagonist with long acting beta-2 agonist (LAMA/LABA)  Clinical criteria:  Patient has a COPD Assessment Test (CAT) score greater than 10  Patient has had 2 or more exacerbations in the previous 12 months  Patient has had one exacerbation requiring hospitalisation in the previous 12 months  Patient has had an eosinophil count greater than or equal to 0.3 × 10^9 cells/L in the previous 12 months  Patient is currently receiving multiple inhaler triple therapy (inhaled corticosteroid with long acting muscarinic antagonist and long acting beta-2 agonist – ICS/LAMA/LABA) and met at least one of the clinical criteria above prior to commencing multiple inhaler triple therapy

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Signed.	Date:	
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PRESCRIBER		PATIENT:
Name:		
Ward:		NHI:
Budesonide	with 9	glycopyrronium and eformoterol
INITIATION Prerequisites	(tick bo	xes where appropriate)
	`	
	Patient possibl	has a diagnosis of COPD confirmed by spirometry or spirometry has been attempted and technically acceptable results are not e
	and	Patient is currently receiving an inhaled corticosteroid with long acting beta-2 agonist (ICS/LABA) or a long acting muscarinic antagonist with long acting beta-2 agonist (LAMA/LABA)
or	lo	Clinical criteria:  Patient has a COPD Assessment Test (CAT) score greater than 10  Patient has had 2 or more exacerbations in the previous 12 months  Patient has had one exacerbation requiring hospitalisation in the previous 12 months  Patient has had an eosinophil count greater than or equal to 0.3 × 10°9 cells/L in the previous 12 months  Patient is currently receiving multiple inhaler triple therapy (inhaled corticosteroid with long-acting muscarinic antagonist and ong-acting beta-2 agonist – ICS/LAMA/LABA) and met at least one of the clinical criteria above prior to commencing multiple inhaler therapy

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Signed.	Date:	
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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.

PRES	CRIE	BER		PATIENT:	
Name	:			Name:	
Ward:				NHI:	
Pirfe	nido	one			
Re-a	ssess siups	smer sites Prese	nt rec (tick cribe	opathic pulmonary fibrosis equired after 12 months ek boxes where appropriate) ed by, or recommended by a respiratory specialist, or in accordance with a bital.	
	and and and	$\circ$	For Pirf	atient has been diagnosed with idiopathic pulmonary fibrosis by a multidisconced vital capacity is between 50% and 90% predicted rfenidone is to be discontinued at disease progression (See Notes) rfenidone is not to be used in combination with subsidised nintedanib	iplinary team including a radiologist
		or or	C	The patient has not previously received treatment with nintedanib  Patient has previously received nintedanib, but discontinued nintedani  Patient has previously received nintedanib, but the patient's disease hor more decline in predicted FVC within any 12 month period since sta	as not progressed (disease progression defined as 10%
Re-a	ssess siups	smer sites Prese	nt red (tick cribe dospi Tre	— idiopathic pulmonary fibrosis equired after 12 months ek boxes where appropriate)  med by, or recommended by a respiratory specialist, or in accordance with a coital.  meatment remains clinically appropriate and patient is benefitting from and the company of	
Note peri		ease	e pro	rogression is defined as a decline in percent predicted FVC of 10% or more	e within any 12 month

I confirm that the above details are correct:

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PRESCRIBER	PATIENT:				
Name:	Name:				
Ward:	NHI:				
Nintedanib					
INITIATION – idiopathic pulmonary fibrosis Re-assessment required after 12 months					
Prerequisites (tick boxes where appropriate)					
O Prescribed by, or recommended by a respiratory specialist, or in ac NZ Hospital.	cordance with a protocol or guideline that has been endorsed by the Health				
Patient has been diagnosed with idiopathic pulmonary fibrosi	is by a multidisciplinary team including a radiologist				
Forced vital capacity is between 50% and 90% predicted					
Nintedanib is to be discontinued at disease progression (See	Note)				
	Nintedanib is not to be used in combination with subsidised pirfenidone				
	The patient has not previously received treatment with pirfenidone or				
O Patient has previously received pirfenidone, but discon	tinued pirfenidone within 12 weeks due to intolerance				
O Patient has previously received pirfenidone, but the par or more decline in predicted FVC within any 12 month	tient's disease has not progressed (disease progression defined as 10% period since starting treatment with pirfenidone)				
CONTINUATION – idiopathic pulmonary fibrosis Re-assessment required after 12 months					
Prerequisites (tick boxes where appropriate)					
O Prescribed by, or recommended by a respiratory specialist, or in ac NZ Hospital.	ccordance with a protocol or guideline that has been endorsed by the Health				
Treatment remains clinically appropriate and patient is benefi	itting from and tolerating treatment				
Nintedanib is not to be used in combination with subsidised p	pirfenidone				
O Nintedanib is to be discontinued at disease progression (See	P Note)				
Note: disease progression is defined as a decline in percent predicted FVC period.	of 10% or more within any 12 month				

I confirm that the above details are correct:	
Signed:	Date:

January 2025

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.

PRES	CRIB	ER			PATIENT:
Name	:				Name:
Ward					NHI:
lvaca	aftor				
	ATION equisi	-	(tick b	poxes where appropriate)	
and				by, or recommended by a respiratory specialist or paedia by the Health NZ Hospital.	trician, or in accordance with a protocol or guideline that has been
	( and	C	Patie	ent has been diagnosed with cystic fibrosis	
		or	0	Patient must have G551D mutation in the cystic fibrosis 1 allele	transmembrane conductance regulator (CFTR) gene on at least
			0	Patient must have other gating (class III) mutation (G124 in the CFTR gene on at least 1 allele	14E, G1349D, G178R, G551S, S1251N, S1255P, S549N and S549R)
	and (	C		ents must have a sweat chloride value of at least 60 mmol	/L by quantitative pilocarpine iontophoresis or by Macroduct sweat
	and ( and	С		tment with ivacaftor must be given concomitantly with star	ndard therapy for this condition
	and	C		ent must not have an acute upper or lower respiratory infectiotics) for pulmonary disease in the last 4 weeks prior to d	ction, pulmonary exacerbation, or changes in therapy (including commencing treatment with ivacaftor
	and and	C	The	dose of ivacaftor will not exceed one tablet or one sachet	twice daily
		$\mathcal{O}$	Appli	icant has experience and expertise in the management of	cystic fibrosis

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:
Elexa	acaft	tor v	ith tezacaftor, ivacaftor and ivacaftor
INITI. Prere		_	ck boxes where appropriate)
	(	С	Patient has been diagnosed with cystic fibrosis
	and ( and	C	Patient is 6 years of age or older
			Patient has two cystic fibrosis-causing mutations in the cystic fibrosis transmembrane regulator (CFTR) gene (one from each parental allele)
		or	Patient has a sweat chloride value of at least 60 mmol/L by quantitative pilocarpine iontophoresis or by Macroduct sweat collection system
	and		
		or	Patient has a heterozygous or homozygous F508del mutation
			Patient has a G551D mutation or other mutation responsive in vitro to elexacaftor/tezacaftor/ivacaftor (see note a)
	and (	C	he treatment must be the sole funded CFTR modulator therapy for this condition
	and (	C	reatment with elexacaftor/tezacaftor/ivacaftor must be given concomitantly with standard therapy for this condition
Note:			
			ions are listed in the Food and Drug Administration (FDA) Trikafta prescribing information accessdata.fda.gov/drugsatfda_docs/label/2021/212273s004lbl.pdf

I confirm that the above details are correct:

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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.

PRES	CRIE	BER	PATIENT:			
Name	:					
Ward:			NHI:			
Dorn	ase	alfa				
Re-a	ssess equis	Prescendor	cystic fibrosis It required after 12 months (tick boxes where appropriate)  cribed by, or recommended by a respiratory physician or paediatrician, or in accordance with a protocol or guideline that has been resed by the Health NZ Hospital.  Patient has a confirmed diagnosis of cystic fibrosis  Patient has previously undergone a trial with, or is currently being treated with, hypertonic saline			
		or or	Patient has required one or more hospital inpatient respiratory admissions in the previous 12 month period  Patient has had 3 exacerbations due to CF, requiring oral or intravenous (IV) antibiotics in in the previous 12 month period  Patient has had 1 exacerbation due to CF, requiring oral or IV antibiotics in the previous 12 month period and a Brasfield score of < 22/25  Patient has a diagnosis of allergic bronchopulmonary aspergillosis (ABPA)			
		sites Preso endor	ON – cystic fibrosis (tick box where appropriate)  cribed by, or recommended by a respiratory physician or paediatrician, or in accordance with a protocol or guideline that has been resed by the Health NZ Hospital.  reatment remains appropriate and the patient continues to benefit from treatment			
Re-a	INITIATION – significant mucus production Re-assessment required after 4 weeks Prerequisites (tick boxes where appropriate)  O Patient is an in-patient and The mucus production cannot be cleared by first line chest techniques					
Re-a	INITIATION – pleural emphyema Re-assessment required after 3 days Prerequisites (tick boxes where appropriate)					
	Patient is an in-patient and Patient diagnoses with pleural emphyema					

#### **Sensory Organs**



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.

PRES	CRIBER	BER PATIENT:			
Name	:	Name:	Name:		
Ward:		NHI:			
Dexa	methas	hasone			
Re-a	ssessmen equisites Preso	N – Diabetic macular oedema sment required after 12 months sites (tick boxes where appropriate)  Prescribed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has belospital.	een endorsed by the Health NZ		
	and or and	O Patient has reduced visual acuity of between 6/9 – 6/48 with functional awareness of reduction in vision  O Patient's disease has progressed despite 3 injections with bevacizumab  O Patient is unsuitable or contraindicated to treatment with anti-VEGF agents	n eye, and up to a maximum		
Re-a	equisites  Preso	ATION – Diabetic macular oedema sment required after 12 months sites (tick boxes where appropriate)  Prescribed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has belospital.  Patient's vision is stable or has improved (prescriber determined)  Dexamethasone implants are to be administered not more frequently than once every 4 months into each of 3 implants per eye per year			
Re-a	ssessmen equisites Preso	O Patient has reduced visual acuity of between 6/9 – 6/48 with functional awareness of reduction in vision	een endorsed by the Health NZ		
	and		n eye, and up to a maximum		

I confirm that the above details are correct:

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

PRESCRIBER		PATIENT:	
Name:		Name:	
Ward:		NHI:	
Dexametha	sone - continued		
Re-assessment Prerequisites		ance with a protocol or guideline that has been endorsed by the Health NZ	
and on an analysis of an analysis o	Patient's vision is stable or has improved (prescriber determine Patient is of child bearing potential and has not yet completed Dexamethasone implants are to be administered not more free of 3 implants per eye per year		

#### **Various**



PRES	CRI	BER		PATIENT:
Name	e:			Name:
Ward	Ward: NHI:			NHI:
Defe	ras	irox		
	sses	ssmen sites	, ,	e with a protocol or guideline that has been endorsed by the Health NZ
and	and	$\circ$	have proven ineffective as measured by serum ferritin let  Treatment with deferiprone has resulted in severe persis  Treatment with deferiprone has resulted in arthritis  Treatment with deferiprone is contraindicated due to a hi	/kg/day monotherapy or deferiprone and desferrioxamine combination therapy vels, liver or cardiac MRI T2*
Re-a	sses	sites	ON  It required after 2 years (tick boxes where appropriate) cribed by, or recommended by a haematologist, or in accordance ital.	te with a protocol or guideline that has been endorsed by the Health NZ
	or	0		nd has resulted in clinical stability or continued improvement in all three

I confirm that the above details are correct:	
Signed:	Date:

#### Form RS1445 January 2025

#### HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:	
Deferiprone		
INITIATION Prerequisites (tick box where appropriate)		
O Patient has been diagnosed with chronic iron overload due to congenital inherited anaemia or acquired red cell aplasia		

I confirm that the above details are correct:

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

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Povidone-iodine - Vaginal tab 200 mg	
INITIATION	
Prerequisites (tick box where appropriate)	
O Rectal administration pre-prostate biopsy	

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Chlorhexidine with cetrimide		
INITIATION Re-assessment required after 3 months Prerequisites (tick boxes where appropriate)  O Patient has burns that are greater than 30% of total body surface area (BSA) and O For use in the perioperative preparation and cleansing of large burn areas requiring debridement/skin grafting and O The use of 30 ml ampoules is impractical due to the size of the area to be covered		
CONTINUATION Re-assessment required after 3 months Prerequisites (tick box where appropriate)  The treatment remains appropriate for the patient and the patient is benefiting from the treatment		

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Signed.	Date:	
Oigilica.	 Daic.	

#### Special Foods



PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Carbohydrate	
INITIATION – Use as an additive Prerequisites (tick boxes where appropriate)	
Cystic fibrosis  O Chronic kidney disease  Or Cancer in children  Or Cancers affecting alimentary tract where there are material or Faltering growth in an infant/child  Or Bronchopulmonary dysplasia  Or Premature and post premature infant  Or Inborn errors of metabolism	alabsorption problems in patients over the age of 20 years
INITIATION – Use as a module Prerequisites (tick box where appropriate)  Or For use as a component in a modular formula made from a the Pharmaceutical Schedule or breast milk Note: Patients are required to meet any Special Authority criteria ass	t least one nutrient module and at least one further product listed in Section D of
Tote. I aliens are required to meet any Special Authority Criteria ass	noclated with an of the products used in the modular formula.

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.

Schedule. For community funding, see the Special Authority Criteria.	
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Fat	
INITIATION – Use as an additive Prerequisites (tick boxes where appropriate)	
Patient has inborn errors of metabolism or Faltering growth in an infant/child or Bronchopulmonary dysplasia or Fat malabsorption or Lymphangiectasia or Short bowel syndrome or Infants with necrotising enterocolitis	
O Biliary atresia  or O For use in a ketogenic diet  or O Chyle leak  or O Ascites  or O Patient has increased energy requirements, and for whom diet	ary measures have not been successful
INITIATION – Use as a module Prerequisites (tick box where appropriate)  Or For use as a component in a modular formula made from at least on the Pharmaceutical Schedule or breast milk.  Note: Patients are required to meet any Special Authority criteria associated with the properties of the properti	e nutrient module and at least one further product listed in Section D of with all of the products used in the modular formula.

I confirm that the above details are correct:

C:	D-1	
Signeg.	 Date:	
Cigiloa.	 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:
Protein	
INITIATION – Use as an additive Prerequisites (tick boxes where appropriate)	
O Protein losing enteropathy or O High protein needs	
INITIATION – Use as a module Prerequisites (tick box where appropriate)  Or For use as a component in a modular formula made from at least or the Pharmaceutical Schedule or breast milk.  Note: Patients are required to meet any Special Authority criteria associated with the properties of the properti	ne nutrient module and at least one further product listed in Section D of with all of the products used in the modular formula.

I confirm that the above details are correct:

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Oigilica.	 Duic.	

PRESCRI	BER		PATIENT:
Name:			Name:
Ward:			NHI:
Carbohy	ydra	te and fat supplement	
INITIATIO Prerequi		(tick boxes where appropriate)	
and	$\circ$	Infant or child aged four years or under	
	or	O Cystic fibrosis	
	or	Cancer in children	
	or	Faltering growth     Bronchopulmonary dysplasia	
	or	O Premature and post premature infants	

I confirm that the above details are correct:

0:	D - 1 - 1	

PRES	SCF	IBER	PATIENT:
Name	э: .		Name:
Ward	:		NHI:
Meta	abo	lic Products	
INITI		ON isites (tick boxes where appropriate)	
		O For the dietary management of inherited metabolic disease	
	or	O Patient has adrenoleukodystrophy	

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PRES	CRI	BER		PATIENT:
Name	:			Name:
Ward:				NHI:
Diab	etic	Pro	ducts	
INITI Prere			(tick boxes where appropriate)	
		O	For patients with type I or type II diabetes suffering weight loss	s and malnutrition that requires nutritional support
	or	0	For patients with pancreatic insufficiency	
	or	0	For patients who have, or are expected to, eat little or nothing	for 5 days
	or	0		nutrient losses and/or increased nutritional needs from causes such as
	or	$\bigcirc$	catabolism	
	or		For use pre- and post-surgery	
	or	$\circ$	For patients being tube-fed	
		$\bigcirc$	For tube-feeding as a transition from intravenous nutrition	

I confirm that the above details are correct:	
Signed:	Date:

PRES	CRI	BER		PATIENT:
Name	:			Name:
Ward:				NHI:
Elem	en	tal a	nd Semi-Elemental Products	
INITI. Prere			(tick boxes where appropriate)	
	or or	<ul><li>O</li><li>O</li><li>O</li></ul>	Malabsorption Short bowel syndrome Enterocutaneous fistulas	
	or or or	O O O	Eosinophilic enteritis (including oesophagitis)  Inflammatory bowel disease  Acute pancreatitis where standard feeds are not tolerated  Patients with multiple food allergies requiring enteral feeding	

I confirm that the above details are correct:	
Signed:	Date:

PRES	CRI	BER		PATIENT:	
Name	:			Name:	
Ward:				NHI:	
Fat-r	nod	lified	l feed		
INITI Prere			(tick boxes where appropriate)		
	or	0	Patient has metabolic disorders of fat metabolism		
O Patient has a chyle leak					
	or	0	Modified as a modular feed, made from at least one nutrient me Pharmaceutical Schedule, for adults	odule and at least one further product listed in Section D of the	

Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Hepatic Products	
INITIATION Prerequisites (tick box where appropriate)	
O For children (up to 18 years) who require a liver transplant	

C:	D-1	
Signed.	Date:	
Oigilica.	 Duic.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
High Calorie Products	
INITIATION Prerequisites (tick boxes where appropriate)  Or Patient is fluid volume or rate restricted or Patient requires low electrolyte  Or Cystic fibrosis  Or Any condition causing malabsorption  Or Faltering growth in an infant/child  Or Increased nutritional requirements  and  Patient has substantially increased metabolic requirements	ents

I confirm that the above details are correct:

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Oigilica.	 Duic.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
High protein enteral feed	
INITIATION Prerequisites (tick boxes where appropriate)  The patient has a high protein requirement  Patient has liver disease  Patient is obese (BMI > 30) and is undergoing surgery  Patient is fluid restricted  Patient's needs cannot be more appropriately met using	g high calorie product

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Oigilica.	 Duic.	

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Extensively hyd	ydrolysed formula		
INITIATION Prerequisites (tick	ick boxes where appropriate)		
and	O Cows' milk formula is inappropriate due to severe intolerance or allergy to its protein content		
	O Soy milk formula has been reasonably trialled without resolution of symptoms or		
	O Soy milk formula is considered clinically inappropriate or contraindicated		
or O Sev	Severe malabsorption		
or Sho	Short bowel syndrome		
O Intra	ntractable diarrhoea		
	Biliary atresia		
or O Cho	Cholestatic liver diseases causing malsorption		
or O Cys	Cystic fibrosis		
or O Pro	Proven fat malabsorption		
or O Sev	Severe intestinal motility disorders causing significant malabsorption		
or	ntestinal failure		
or	For step down from Amino Acid Formula		
	ote: A reasonable trial is defined as a 2-4 week trial, or signs of an immediate IgE mediated allergic reaction.		
CONTINUATION Prerequisites (tick	N ick boxes where appropriate)		
O An a	An assessment as to whether the infant can be transitioned to a cows' milk protein or soy infant formu	ıla has been undertaken	
and The	The outcome of the assessment is that the infant continues to require an extensively hydrolysed infan	t formula	

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:
Preterm formula	
INITIATION Prerequisites (tick box where appropriate)	
O For infants born before 33 weeks' gestation or weighing less than 1.	5 kg at birth

I confirm that the above details are correct:

Signed: Date:

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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:
Paediatric oral/enteral feed 1 kcal/ml	
INITIATION – Fluid restricted or volume intolerance with faltering growth Prerequisites (tick boxes where appropriate)  Or  The patient is fluid restricted or volume intolerant or  The patient has increased nutritional requirements due to and  Patient is under 18 months old and weighs less than 8kg	
Note: 'Volume intolerant' patients are those who are unable to tolerate an ade patients should have first trialled appropriate clinical alternative treatments, su	

PRESC	CRIB	ER	PATIENT:
Name:			Name:
Ward:			NHI:
Enter	al li	qui	peptide formula
INITIA			ck boxes where appropriate)
	(	$\overline{}$	atient has impaired gastrointestinal function and either cannot tolerate polymeric feeds, or polymeric feeds are unsuitable
1	and		O Severe malabsorption
		or	Short bowel syndrome
		or	O Intractable diarrhoea
		or	O Biliary atresia
		or	Cholestatic liver diseases causing malabsorption
		or	Cystic fibrosis
		or	Proven fat malabsorption
		or	Severe intestinal motility disorders causing significant malabsorption
		or	O Intestinal failure
			O The patient is currently receiving funded amino acid formula and
			The patient is to be trialled on, or transitioned to, an enteral liquid peptide formula
	and		
		or	A semi-elemental or partially hydrolysed powdered feed has been reasonably trialled and considered unsuitable
			For step down from intravenous nutrition
Note:	A rea	ason	ole trial is defined as a 2-4 week trial.
CONT			ck boxes where appropriate)
	(		n assessment as to whether the patient can be transitioned to a cows milk protein or soy infant formula or extensively hydrolysed or a specific product of the patient can be transitioned to a cows milk protein or soy infant formula or extensively hydrolysed or a specific product of the patient can be transitioned to a cows milk protein or soy infant formula or extensively hydrolysed or a cows milk protein or soy infant formula or extensively hydrolysed or a cows milk protein or soy infant formula or extensively hydrolysed or a cows milk protein or soy infant formula or extensively hydrolysed or a cows milk protein or soy infant formula or extensively hydrolysed or a cows milk protein or soy infant formula or extensively hydrolysed or a cows milk protein or soy infant formula or extensively hydrolysed or a cows milk protein or soy infant formula or extensively hydrolysed or a cows milk protein or soy infant formula or extensively hydrolysed or a cows milk protein or soy infant formula or extensively hydrolysed or a cows milk protein or a cows
	and (	$\overline{}$	he outcome of the assessment is that the patient continues to require an enteral liquid peptide formula

I confirm that the above details are correct:	
Signed:	Date:

Schedule. For community funding, see the Special Authority Criteria.		
PRESCRIBER	PATIENT:	
ne:		
Ward:	NHI:	
Amino acid formula		
INITIATION Prerequisites (tick boxes where appropriate)		
Extensively hydrolysed formula has been reasonably trialled for allergy or malabsorption  History of anaphylaxis to cows' milk protein formula or dairy por  Eosinophilic oesophagitis  Or  Ultra-short gut  Or  Severe Immune deficiency	or 2-4 weeks and is inappropriate due to documented severe intolerance roducts	
CONTINUATION Prerequisites (tick boxes where appropriate)		
An assessment as to whether the infant can be transitioned to been undertaken  The outcome of the assessment is that the infant continues to and  Amino acid formula is required for a nutritional deficit	o a cows' milk protein, soy, or extensively hydrolysed infant formula has require an amino acid infant formula	
INITIATION – patients who are currently funded under RS1502 or SA155 Re-assessment required after 3 months  Prerequisites (tick boxes where appropriate)	7	
Patient has a valid initiation or renewal approval for extensivel and Patient is unable to source funded Aptamil powder at this time and The approval only applies to funded dispensings of Neocate C		
Note: This criteria is short term funding to cover an out-of-stock situation on s Restriction RS1502. There is no continuation criteria under this criterion.		
I confirm that the above details are correct:		

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

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
High fat formula	
INITIATION	
Prerequisites (tick box where appropriate)	
For patients with intractable epilepsy, pyruvate dehy requiring a ketogenic diet	rdrogenase deficiency or glucose transported type-1 deficiency and other conditions

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Paediatric Products	
INITIATION Prerequisites (tick boxes where appropriate)  Child is aged one to ten years and	
The child is being fed via a tube or a tube is to be insert or  Any condition causing malabsorption  Faltering growth in an infant/child  r Increased nutritional requirements  r The child is being transitioned from TPN or tube feeding or  The child has eaten, or is expected to eat, little or nothing	g to oral feeding

I confirm that the above details are correct:

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Signed.	Date:	
Oigilica.	 Daic.	

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:
Low electrolyte oral feed	
INITIATION Prerequisites (tick box where appropriate)	
O For children (up to 18 years) with acute or chronic kidney disease	

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:
Low electrolyte oral feed	
INITIATION Prerequisites (tick box where appropriate)	
O For patients with acute or chronic kidney disease	

I confirm that the above details are correct:

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

PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Preoperative carbohydrate feed 0.5 kcal/ml				
INITIATION Prerequisites (tick box where appropriate)				
O Maximum of 400 ml as part of an Enhanced Recovery After Surgery (ERAS) protocol 2 to 3 hours before major abdominal surgery				

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
High arginine oral feed 1.4 kcal/ml	
INITIATION Prerequisites (tick box where appropriate)	
O Three packs per day for 5 to 7 days prior to major gastrointestinal, h	nead or neck surgery

C:	D-1	
Signed.	Date:	
Oigilica.	 Daic.	

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PRESCR	IBER	PATIENT:
Name: .		
Ward:		NHI:
Standa	rd Fe	eds
INITIATI		
Prerequ	isites	(tick boxes where appropriate)
	For	patients with malnutrition, defined as any of the following:
		O BMI < 18.5
	or	O Greater than 10% weight loss in the last 3-6 months
	or	O BMI < 20 with greater than 5% weight loss in the last 3-6 months
or	0	For patients who have, or are expected to, eat little or nothing for 5 days
or	$\overline{}$	
or	$\bigcirc$	For patients who have a poor absorptive capacity and/or high nutrient losses and/or increased nutritional needs from causes such as catabolism
	$\circ$	For use pre- and post-surgery
or	0	For patients being tube-fed
or	0	For tube-feeding as a transition from intravenous nutrition
or	0	For any other condition that meets the community Special Authority criteria

I confirm that the above details are correct:	
Signed:	Date:

### **Vaccines**



PRES	CRII	BER		PATIENT:
Name	:			Name:
Ward				NHI:
Diph	the	ria, t	tetanus, pertussis and polio vaccine	
INITI Prer			(tick boxes where appropriate)	
	or	0	A single dose for children up to the age of 7 who have comple	ted primary immunisation
	A course of up to four vaccines is funded for catch up programmes for children (to the age of 10 years) to complete full primary immunisation		nmes for children (to the age of 10 years) to complete full primary	
	O An additional four doses (as appropriate) are funded for (re-)immunisation for patients post HSCT, or chemotherapy; pre- or post splenectomy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens			
O Five doses will be funded for children requiring solid organ transplantation			nsplantation	

Note: Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes

PRES	CRI	BER	R PATIENT	:
Name	:		Name: .	
Ward:			NHI:	
Diph	the	ria, t	, tetanus, pertussis, polio, hepatitis B and haemophilus	influenzae type B vaccine
Prere			Up to four doses for children under the age of 10 years for primary immular and additional four doses (as appropriate) for (re-)immunisation of childre transplantation  An additional four doses (as appropriate) for (re-)immunisation of childre or post splenectomy; undergoing renal dialysis and other severely immunication of the five doses for children under the age of 10 years receiving solid or	n under the age of 18 years post haematopoietic stem cell n under the age of 10 years who are post chemotherapy; pre nosuppressive regimens

Note: A course of up-to four vaccines is funded for catch up programmes for children (up to and under the age of 10 years) to complete full primary immunisation. Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes.

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:
Bacillus calmette-guerin vaccine	
INITIATION Prerequisites (tick boxes where appropriate)  For infants at increased risk of tuberculosis defined as:	
Living in a house or family with a person with current or past h	istory of TB the last 5 years lived in a country with a rate of TB > or equal to 40 per
and O During their first 5 years will be living 3 months or longer in a c	country with a rate of TB > or equal to 40 per 100,000

Note: A list of countries with high rates of TB are available at http://www.health.govt.nz/tuberculosis (Search for Downloads) or www.bcgatlas.org/index.php

PRES	CRI	BER	I	PATIENT:			
lame	:			Name:			
Vard:				NHI:			
iph	the	ria, t	tetanus and pertussis vaccine				
INITI	ATIC	N					
Prere	equi	sites	(tick boxes where appropriate)				
		O	A single dose for pregnant women in the second or third trimest	er of each pregnancy; or			
	or	0	A single dose for parents or primary caregivers of infants admitted to a Neonatal Intensive Care Unit or Specialist Care Baby Unit for more than 3 days, who had not been exposed to maternal vaccination at least 14 days prior to birth; or				
	or	0	A course of up to four doses is funded for children from age 7 up the age of 18 years inclusive to complete full primary immunisation				
	or	0	An additional four doses (as appropriate) are funded for (re-)immunisation for patients post haematopoietic stem cell transplantation or chemotherapy; pre or post splenectomy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens				
	or	0	A single dose for vaccination of patients aged from 65 years old				
	or	0	A single dose for vaccination of patients aged from 45 years old who have not had 4 previous tetanus doses				
	or	0	For vaccination of previously unimmunised or partially immunised patients				
	or	0	For revaccination following immunosuppression				
	or	0	For boosting of patients with tetanus-prone wounds				

Note: Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes.

I confirm that the above details are correct:	
Signed:	Date:

PRES	SCRI	BER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Haer	nop	ohilu	s influenzae type B vaccine	
	sses	ssmen	nt required after 1 dose (tick boxes where appropriate)	
		0	For primary vaccination in children	
	An additional dose (as appropriate) is funded for (re-)immunisation for patients post haematopoietic stem cell transplantation, or chemotherapy; functional asplenic; pre or post splenectomy; pre- or post solid organ transplant, pre- or post cochlear implants, renal dialysis and other severely immunosuppressive regimens			
	or	0	For use in testing for primary immunodeficiency diseases, on t	the recommendation of an internal medicine physician or paediatrician

PRESCRI	RIBER PATIENT:			
Name:				
Ward:			NHI:	
Meningo	ococ	cal (	A, C, Y and W-135) conjugate vaccine	
INITIATIO				
Prerequi	sites (	tick b	poxes where appropriate)	
		0	Up to three doses and a booster every five years for patients pre- and post splenectomy and for patients with HIV, complement deficiency (acquired or inherited), functional or anatomic asplenia or pre or post solid organ transplant	
	or	0	One dose for close contacts of meningococcal cases of any group	
	One dose for person who has previously had meningococcal disease of any group			
	O A maximum of two doses for bone marrow transplant patients			
	or	0	A maximum of two doses for person pre and post-immunosuppression*	
or				
	and		Person is aged between 13 and 25 years, inclusive	
		or	One dose for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, or prisons	
			One dose for individuals who turn 13 years of age while living in boarding school hostels	

Note: children under seven years of age require two doses 8 weeks apart, a booster dose three years after the primary series and then five yearly.

\*Immunosuppression due to steroid or other immunosuppressive therapy must be for a period of greater than

\*Immunosuppression due to steroid or other immunosuppressive therapy must be for a period of greater than 28 days.

I confirm that the above details are correct:

Signed: \_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_

schedules with meningococcal ACWY vaccine.

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:
Meningococcal (A, C, Y and W-135) conjugate va	ccine
INITIATION – Children under 12 months of age Prerequisites (tick boxes where appropriate)	
anatomic asplenia, HIV, complement deficiency (  A maximum of three doses (dependant on age a or  A maximum of three doses (dependant on age a or  A maximum of three doses (dependant on age a or	t first dose) for patients pre- and post- splenectomy and for patients with functional or (acquired or inherited), or pre- or post- solid organ transplant  t first dose) for close contacts of meningococcal cases of any group  t first dose) for child who has previously had meningococcal disease of any group  t first dose) for bone marrow transplant patients  t first dose) for child pre- and post-immunosuppression*
Note: infants from 6 weeks to less than 6 months of age require than 12 months of age require a 1+1 schedule. Refer to the In	

\*Immunosuppression due to steroid or other immunosuppressive therapy must be for a period of greater than 28 days.

I confirm that the above details are correct: Signed: ...... Date: ......

PRESCRIBER	PATIENT:	
ame:		
Ward:	NHI:	
Pneumococcal (PCV13) conjugate vaccine		
INITIATION – Primary course for previously unvaccinated Re-assessment required after 3 doses  Prerequisites (tick box where appropriate)		
A primary course of three doses for previously unvac	cinated children up to the age of 59 months inclusive	
INITIATION – High risk individuals who have received PCV Re-assessment required after 2 doses Prerequisites (tick box where appropriate)  Two doses are funded for high risk individuals (over t primary course of PCV10	he age of 12 months and under 18 years) who have previously received two doses of the	
INITIATION – High risk children aged under 5 years Re-assessment required after 4 doses Prerequisites (tick boxes where appropriate)		
O Up to an additional four doses (as appropriate)	are funded for the (re)immunisation of high-risk children aged under 5 years	
	tion therapy, vaccinate when there is expected to be a sufficient immune response	
Or Primary immune deficiencies		
O HIV infection		
O Renal failure, or nephrotic syndrome		
O Are immune-suppressed following organ	transplantation (including haematopoietic stem cell transplant)	
Cochlear implants or intracranial shunts		
O Cerebrospinal fluid leaks		
	e than two weeks, and who are on an equivalent daily dosage of prednisone of 2 mg/kg more than 10 kg on a total daily dosage of 20 mg or greater	
	sthma treated with high-dose corticosteroid therapy)	
O Pre term infants, born before 28 weeks gestation		
O Cardiac disease, with cyanosis or failure		
O Diabetes		
O Down syndrome		
O Who are pre-or post-splenectomy, or with	n functional asplenia	

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Pneumococcal (PCV13) conjugate vaccine - continued			
INITIATION – High risk individuals 5 years and over Re-assessment required after 4 doses			
Prerequisites (tick box where appropriate)			
O Up to an additional four doses (as appropriate) are funded for the (re-)immunisation of individuals 5 years and over with HIV, pre or post haematopoietic stem cell transplantation, or chemotherapy; pre- or post splenectomy; functional asplenia, pre- or post- solid organ transplant, renal dialysis, complement deficiency (acquired or inherited), cochlear implants, intracranial shunts, cerebrospinal fluid leaks or primary immunodeficiency			
INITIATION – Testing for primary immunodeficiency diseases			
Prerequisites (tick box where appropriate)			
O For use in testing for primary immunodeficiency diseases, on the rec	commendation of an internal medicine physician or paediatrician		
Note: Please refer to the Immunisation Handbook for the appropriate schedu	alle for catch up programmes		

I confirm that the above details are correct:

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RESCRIE	BER		PATIENT:	
lame: Name:				
Ward: NHI:				
neumo	coc	cal (	I (PPV23) polysaccharide vaccine	
Re-assess Prerequis	smen sites For pa asple	t requ (tick t atient nia, p	h risk patients equired after 3 doses k box where appropriate) ents with HIV, for patients post haematopoietic stem cell transplant, or chemotherapy; pre- or post, pre- or post-solid organ transplant, renal dialysis, complement deficiency (acquired or inherited deficiency	
NITIATIO Re-assess	N – H smen	<b>ligh i</b> t requ	h risk children equired after 2 doses ek boxes where appropriate)	
Terequis				
and		Patie	atient is a child under 18 years for (re-)immunisation	
	or	$\bigcirc$	On immunosuppressive therapy or radiation therapy, vaccinate when there is expected to be With primary immune deficiencies	a sufficient immune response
	or	0	With HIV infection	
	or	0	With renal failure, or nephrotic syndrome	
	or	0	Who are immune-suppressed following organ transplantation (including haematopoietic stem	n cell transplant)
	or	0	With cochlear implants or intracranial shunts	
	or	0	With cerebrospinal fluid leaks	
	or	0	Receiving corticosteroid therapy for more than two weeks, and who are on an equivalent dai per day or greater, or children who weigh more than 10 kg on a total daily dosage of 20 mg c	
	or	0	With chronic pulmonary disease (including asthma treated with high-dose corticosteroid there	ару)
	or	0	Pre term infants, born before 28 weeks gestation	
	or	0	With cardiac disease, with cyanosis or failure	
	or	0	With diabetes	
	or	0	With Down syndrome	
	Ji	0	Who are pre-or post-splenectomy, or with functional asplenia	
			ting for primary immunodeficiency diseases k box where appropriate)	
O	For u	se in	in testing for primary immunodeficiency diseases, on the recommendation of an internal medicin	e physician or paediatrician
		JO 111	in testing for primary initial occition of discussion, on the recommendation of air internal medicin	— physician of pacaratrician

I confirm that the above details are correct:

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Salmonella typhi vaccine	
INITIATION Prerequisites (tick box where appropriate)	
O For use during typhoid fever outbreaks	

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ard:  NHI:  *** *** *** *** *** *** *** *** ***	RESCRIBER	PATIENT:
eningococcal B multicomponent vaccine  ###################################	ame:	Name:
IITIATION – Primary immunisation for children up to 12 months of age e-assessment required after 3 doses rerequisites (tick boxes where appropriate)  Or Three doses for children up to 12 months of age (inclusive) for primary immunisation or Up to three doses (dependent on age at first dose) for a catch-up programme for children from 13 months to 59 months of age (inclusive) for primary immunisation, from 1 March 2023 to 31 August 2025  IITIATION – Person is one year of age or over rerequisites (tick boxes where appropriate)  O Up to two doses and a booster every five years for patients pre- and post-splenectomy and for patients with functional or anatomic asplenia, HIV, complement deficiency (acquired or inherited), or pre- or post-solid organ transplant or Up to two doses for close contacts of meningococcal cases of any group or Up to two doses for person who has previously had meningococcal disease of any group or Up to two doses for person who has previously had meningococcal disease of any group or Up to two doses for person pre- and post-immunosuppression*  IIITIATION – Person is aged between 13 and 25 years (inclusive) e-assessment required after 2 doses rerequisites (tick boxes where appropriate)  O Person is aged between 13 and 25 years (inclusive) and  O Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons	ard:	NHI:
Person is one year of age or over rerequisites (tick boxes where appropriate)  TITIATION – Person is one year of age or over rerequisites (tick boxes where appropriate)  Up to two doses and a booster every five years for patients pre- and post-splenectomy and for patients with functional or anatomic asplenia, HIV, complement deficiency (acquired or inherited), or pre- or post-solid organ transplant  Up to two doses for close contacts of meningococcal cases of any group  Up to two doses for person who has previously had meningococcal disease of any group  Up to two doses for person who has previously had meningococcal disease of any group  Up to two doses for person pre- and post-immunosuppression*  IITIATION – Person is aged between 13 and 25 years (inclusive)  Person is aged between 13 and 25 years (inclusive)  Or Person is aged between 13 and 25 years (inclusive)  Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons	eningococcal B multicomponent vaccine	
Three doses for children up to 12 months of age (inclusive) for primary immunisation  Or  Up to three doses (dependent on age at first dose) for a catch-up programme for children from 13 months to 59 months of age (inclusive) for primary immunisation, from 1 March 2023 to 31 August 2025  INTIATION – Person is one year of age or over rerequisites (tick boxes where appropriate)  Up to two doses and a booster every five years for patients pre- and post-splenectomy and for patients with functional or anatomic asplenia, HIV, complement deficiency (acquired or inherited), or pre- or post-solid organ transplant  Or  Up to two doses for close contacts of meningococcal cases of any group  or  Up to two doses for person who has previously had meningococcal disease of any group  or  Up to two doses for bone marrow transplant patients  or  Up to two doses for person pre- and post-immunosuppression*  INTIATION – Person is aged between 13 and 25 years (inclusive)  e-assessment required after 2 doses  rerequisites (tick boxes where appropriate)  Person is aged between 13 and 25 years (inclusive)  Or  Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons		hs of age
Up to three doses (dependent on age at first dose) for a catch-up programme for children from 13 months to 59 months of age (inclusive) for primary immunisation, from 1 March 2023 to 31 August 2025  IITIATION – Person is one year of age or over rerequisites (tick boxes where appropriate)  Up to two doses and a booster every five years for patients pre- and post-splenectomy and for patients with functional or anatomic asplenia, HIV, complement deficiency (acquired or inherited), or pre- or post-solid organ transplant  Or Up to two doses for close contacts of meningococcal cases of any group  or Up to two doses for person who has previously had meningococcal disease of any group  or Up to two doses for bone marrow transplant patients  or Up to two doses for person pre- and post-immunosuppression*  IITIATION – Person is aged between 13 and 25 years (inclusive)  e-assessment required after 2 doses rerequisites (tick boxes where appropriate)  Person is aged between 13 and 25 years (inclusive)  and  Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons	rerequisites (tick boxes where appropriate)	
(inclusive) for primary immunisation, from 1 March 2023 to 31 August 2025  IITIATION – Person is one year of age or over rerequisites (tick boxes where appropriate)  Up to two doses and a booster every five years for patients pre- and post-splenectomy and for patients with functional or anatomic asplenia, HIV, complement deficiency (acquired or inherited), or pre- or post-solid organ transplant  Up to two doses for close contacts of meningococcal cases of any group  Up to two doses for person who has previously had meningococcal disease of any group  Up to two doses for bone marrow transplant patients  Up to two doses for person pre- and post-immunosuppression*  IITIATION – Person is aged between 13 and 25 years (inclusive)  e-assessment required after 2 doses rerequisites (tick boxes where appropriate)  Person is aged between 13 and 25 years (inclusive)  Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels tertiary education halls of residence, military barracks, Youth Justice residences, or prisons		nclusive) for primary immunisation
Up to two doses and a booster every five years for patients pre- and post-splenectomy and for patients with functional or anatomic asplenia, HIV, complement deficiency (acquired or inherited), or pre- or post-solid organ transplant  Or Up to two doses for close contacts of meningococcal cases of any group  Or Up to two doses for person who has previously had meningococcal disease of any group  Or Up to two doses for bone marrow transplant patients  Or Up to two doses for person pre- and post-immunosuppression*  IIITIATION – Person is aged between 13 and 25 years (inclusive)  e-assessment required after 2 doses rerequisites (tick boxes where appropriate)  Or Person is aged between 13 and 25 years (inclusive)  and  Or Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons		
Up to two doses and a booster every five years for patients pre- and post-splenectomy and for patients with functional or anatomic asplenia, HIV, complement deficiency (acquired or inherited), or pre- or post-solid organ transplant  Up to two doses for close contacts of meningococcal cases of any group  Up to two doses for person who has previously had meningococcal disease of any group  Up to two doses for bone marrow transplant patients  Up to two doses for person pre- and post-immunosuppression*  ITIATION – Person is aged between 13 and 25 years (inclusive)  e-assessment required after 2 doses rerequisites (tick boxes where appropriate)  Person is aged between 13 and 25 years (inclusive)  and  Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons	ITIATION – Person is one year of age or over	
asplenia, HIV, complement deficiency (acquired or inherited), or pre- or post-solid organ transplant  Or Up to two doses for close contacts of meningococcal cases of any group  Or Up to two doses for person who has previously had meningococcal disease of any group  Or Up to two doses for bone marrow transplant patients  Or Up to two doses for person pre- and post-immunosuppression*  IITIATION – Person is aged between 13 and 25 years (inclusive)  e-assessment required after 2 doses  rerequisites (tick boxes where appropriate)  Or Person is aged between 13 and 25 years (inclusive)  and  Or Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons	rerequisites (tick boxes where appropriate)	
Up to two doses for close contacts of meningococcal cases of any group  Or Or Of Up to two doses for person who has previously had meningococcal disease of any group  Or Of Up to two doses for bone marrow transplant patients  Or Of Up to two doses for person pre- and post-immunosuppression*  IITIATION – Person is aged between 13 and 25 years (inclusive)  De-assessment required after 2 doses  rerequisites (tick boxes where appropriate)  Of Person is aged between 13 and 25 years (inclusive)  Of Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons	asplenia, HIV, complement deficiency (acquired or	
Up to two doses for bone marrow transplant patients  Up to two doses for person pre- and post-immunosuppression*  ITIATION – Person is aged between 13 and 25 years (inclusive) assessment required after 2 doses erequisites (tick boxes where appropriate)  Person is aged between 13 and 25 years (inclusive)  and  Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons	O Up to two doses for close contacts of meningococc	al cases of any group
Up to two doses for person pre- and post-immunosuppression*  IITIATION – Person is aged between 13 and 25 years (inclusive) e-assessment required after 2 doses rerequisites (tick boxes where appropriate)  O Person is aged between 13 and 25 years (inclusive) and  Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons		I meningococcal disease of any group
Up to two doses for person pre- and post-immunosuppression*  IITIATION – Person is aged between 13 and 25 years (inclusive) e-assessment required after 2 doses rerequisites (tick boxes where appropriate)  O Person is aged between 13 and 25 years (inclusive)  and  Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons		ts
e-assessment required after 2 doses rerequisites (tick boxes where appropriate)  Person is aged between 13 and 25 years (inclusive)  and  Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons		uppression*
e-assessment required after 2 doses rerequisites (tick boxes where appropriate)  O Person is aged between 13 and 25 years (inclusive)  and  Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons		
Person is aged between 13 and 25 years (inclusive)  Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons		ve)
Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons		
tertiary education halls of residence, military barracks, Youth Justice residences, or prisons		
Two doses for individuals who turn 13 years of age while living in boarding school hostels		
	Two doses for individuals who turn 13 years of	of age while living in boarding school hostels
Note: *Immunosuppression due to corticosteroid or other immunosuppressive therapy must be for a period of greater than 28 days.		nosuppressive therapy must be for a period of

I confirm that the above details are correct:

Signed: Date:

PRES	SCR	IBER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Нера	atiti	is A v	vaccine	
INITI Prer			(tick boxes where appropriate)	
			Two vaccinations for use in transplant patients	
	O Two vaccinations for use in children with chronic liver disease			
	or		One dose of vaccine for close contacts of known hepatitis A ca	ases

PRESC	RIE	BER		PATIENT:
Name:				Name:
Ward:				NHI:
Hepat	itis	В	recombinant vaccine	
INITIA Prerec			(tick boxes where appropriate)	
		0	For household or sexual contacts of known acute hepatitis B p	atients or hepatitis B carriers
	or	0	For children born to mothers who are hepatitis B surface antig	en (HBsAg) positive
	or or	0	For children up to and under the age of 18 years inclusive who additional vaccination or require a primary course of vaccination	o are considered not to have achieved a positive serology and require on
		$\circ$	For HIV positive patients	
	or	$\circ$	For hepatitis C positive patients	
	or	$\circ$	For patients following non-consensual sexual intercourse	
'	or	0	For patients prior to planned immunosuppression for greater the	nan 28 days
•	or	$\circ$	For patients following immunosuppression	
•	or	0	For solid organ transplant patients	
•	or	$\circ$	For post-haematopoietic stem cell transplant (HSCT) patients	
•	or	$\circ$	Following needle stick injury	
•	or	$\circ$	For dialysis patients	
•	or	0	For liver or kidney transplant patients	

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PRES	CRII	BER	PATIENT:
Name:			
Ward:			NHI:
Нера	titis	s B ı	recombinant vaccine
INITIA			
Prere	quis	sites	(tick boxes where appropriate)
		0	For household or sexual contacts of known acute hepatitis B patients or hepatitis B carriers
	or	0	For children born to mothers who are hepatitis B surface antigen (HBsAg) positive
	or	0	For children up to and under the age of 18 years inclusive who are considered not to have achieved a positive serology and require additional vaccination or require a primary course of vaccination
	or	0	For HIV positive patients
	or	0	For hepatitis C positive patients
	or	0	For patients following non-consensual sexual intercourse
	or	0	For patients prior to planned immunosuppression for greater than 28 days
	or	0	For patients following immunosuppression
	or	0	For solid organ transplant patients
	or	0	For post-haematopoietic stem cell transplant (HSCT) patients
	or	0	Following needle stick injury

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PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Influenza vaccine Inj 60 mcg in 0.5 ml syringe (quadrivalen	t vaccine)		
INITIATION – People over 65 Prerequisites (tick box where appropriate)			
O The patient is 65 years of age or over			
INITIATION – cardiovascular disease Prerequisites (tick boxes where appropriate)			
O Ischaemic heart disease  or O Congestive heart failure  or O Rheumatic heart disease  or O Congenital heart disease  or O Cerebro-vascular disease			
Note: hypertension and/or dyslipidaemia without evidence of end-organ disea	ase is excluded from funding.		
INITIATION – chronic respiratory disease Prerequisites (tick boxes where appropriate)			
O Asthma, if on a regular preventative therapy O Other chronic respiratory disease with impaired lung function			
Note: asthma not requiring regular preventative therapy is excluded from funding.			

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I confirm that the above details are correct:

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

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Influenza vaccine Inj 60 mcg in 0.5 ml syringe (quadrivale	ent vaccine) - continued
INITIATION – Other conditions Prerequisites (tick boxes where appropriate)	
O Diabetes  or O Chronic renal disease  or O Any cancer, excluding basal and squamous skin cand  or O Autoimmune disease  or O Immune suppression or immune deficiency  or O HIV  or O Transplant recipient  or O Neuromuscular and CNS diseases/ disorders  or O Haemoglobinopathies  or O Is a child on long term aspirin  or O Has a cochlear implant  or O Errors of metabolism at risk of major metabolic decor  or O Pre and post splenectomy  or O Down syndrome  or O Is pregnant  or O Is a child 4 years of age or under (inclusive) who has respiratory illness  or O Patients in a long-stay inpatient mental health care unit or velospital	
Prerequisites (tick boxes where appropriate)	
O Schizophrenia or	
Major depressive disorder	
O Bipolar disorder	
O Schizoaffective disorder	
O Person is currently accessing secondary or tertiary mental	health and addiction services

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Measles, mumps and rubella vaccine			
INITIATION – first dose prior to 12 months Re-assessment required after 3 doses Prerequisites (tick boxes where appropriate)  Or Or Or For primary vaccination in children or Or For revaccination following immunosuppression or Or For any individual susceptible to measles, mumps or rubella			
INITIATION – first dose after 12 months Re-assessment required after 2 doses Prerequisites (tick boxes where appropriate)  Or For primary vaccination in children or Or For revaccination following immunosuppression or Or For any individual susceptible to measles, mumps or rubella			
Note: Please refer to the Immunisation Handbook for appropriate schedule	for catch up programmes.		

I confirm that the above details are correct:	
Signed:	Date:

#### Form RS1398 January 2025

### HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 509

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:
Poliomyelitis vaccine	
INITIATION Re-assessment required after 3 doses Prerequisites (tick boxes where appropriate)  Or For partially vaccinated or previously unvaccinated individuals	
or Sor revaccination following immunosuppression	

Note: Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes.

		PATIENT:
lame:		Name:
Vard:		NHI:
aricella vaccii	ne [Chickenpox vaccine]	
	nary vaccinations quired after 1 dose s boxes where appropriate)	
or O For	y infant born on or after 1 April 2016 r previously unvaccinated children turning 11 years old on ickenpox)	or after 1 July 2017, who have not previously had a varicella infection
INITIATION – other conditions Re-assessment required after 2 doses Prerequisites (tick boxes where appropriate)		
or or or	<ul> <li>r non-immune patients:</li> <li>) With chronic liver disease who may in future be candidated.</li> <li>) With deteriorating renal function before transplantation.</li> <li>) Prior to solid organ transplant.</li> <li>) Prior to any elective immunosuppression*</li> </ul>	ates for transplantation

greater than 28 days

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Human papillomavirus (6, 11, 16, 18, 31, 33, 45, 52 and 58)	vaccine [HPV]
INITIATION – Children aged 14 years and under Re-assessment required after 2 doses Prerequisites (tick box where appropriate)  Children aged 14 years and under	
INITIATION – other conditions Prerequisites (tick boxes where appropriate)	
O Up to 3 doses for people aged 15 to 26 years inclusive	
People aged 9 to 26 years inclusive	
O Up to 3 doses for confirmed HIV infection	
O Up to 3 doses people with a transplant (including	stem cell)
O Up to 4 doses for Post chemotherapy	
INITIATION – Recurrent Respiratory Papillomatosis Prerequisites (tick boxes where appropriate)	
O Maximum of two doses for children aged 14 years and	under
O Maximum of three doses for people aged 15 years and	over
The person has recurrent respiratory papillomatosis and	
O The person has not previously had an HPV vaccine	

I confirm that the above details are correct:

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

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Rotavirus oral vaccine	
INITIATION Re-assessment required after 2 doses	
Prerequisites (tick boxes where appropriate)	
First dose to be administered in infants aged under	r 14 weeks of age
No vaccination being administered to children aged	d 24 weeks or over

I confirm that the above details are correct:	
Signed:	Date:

BER		PATIENT:
		Name:
		NHI:
ZO	ster vaccine [shingles vaccine]	
smer	at required after 2 doses	
	Pre- or post-solid organ transplant  Haematological malignancies  People living with poorly controlled HIV infection  Planned or receiving disease modifying anti-rheumatic drugs (	DMARDs – targeted synthetic, biologic, or conventional synthetic) for
	N – I	popular transplant  Pre- and post-haematopoietic stem cell transplant or cellular transplant  Pre- or post-solid organ transplant  Haematological malignancies  People living with poorly controlled HIV infection  Planned or receiving disease modifying anti-rheumatic drugs (in polymyalgia rheumatica, systemic lupus erythematosus or rheumatical stage kidney disease (CKD 4 or 5);

I confirm that the above details are correct:	
Signed:	Date:

# 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	PATIENT:
Name:	Name:
Ward:	NHI:
COVID-19 vaccine	
INITIATION – initial dose	
Prerequisites (tick boxes where appropriate)	
One dose for previously unvaccinated people aged 12-15 years  Or  Up to three doses for immunocompromised people aged 12-15  or  Up to two doses for previously unvaccinated people 16-29 years  Or  Or  One dose for previously unvaccinated people aged 30 and older	years old s old iness
INITIATION – additional dose Prerequisites (tick box where appropriate)	
One additional dose every 6 months for people aged 30 years and or	ver, additional dose is given at least 6 months after last dose
CONTINUATION – additional dose Prerequisites (tick box where appropriate)  One additional dose every 6 months for people aged 30 years and or	ver, additional dose is given at least 6 months after last dose

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# 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	PATIENT:
Name:	Name:
Ward:	NHI:
COVID-19 vaccine	
INITIATION – initial dose	
Prerequisites (tick boxes where appropriate)	
One dose for previously unvaccinated people aged 12-15 year or	
Up to three doses for immunocompromised people aged 12-19 or	5 years old
O Up to two doses for previously unvaccinated people 16-29 year	rs old
O Up to four doses for people aged 16-29 at high risk of severe i	Iness
One dose for previously unvaccinated people aged 30 and old	er
INITIATION – additional dose	
Prerequisites (tick box where appropriate)	
One additional dose every 6 months for people aged 30 years and o	ver, additional dose is given at least 6 months after last dose
CONTINUATION – additional dose Prerequisites (tick box where appropriate)	
One additional dose every 6 months for people aged 30 years and o	ver, additional dose is given at least 6 months after last dose

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Oigilica.	 Duic.	

PRES	SCR	BER	PATIENT:
Name	e:		Name:
Ward	l:		NHI:
COV	ID-	19 vaccine	
		ON – initial dose isites (tick boxes where appropriate)	
		One dose for previously unvaccinated children aged 5-11 year	rs old
	or	O Up to three doses for immunocompromised children aged 5-1	1 years old

#### Form RS2042 January 2025

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:
COVID-19 vaccine	
INITIATION – initial dose Prerequisites (tick box where appropriate)	
O Up to three doses for previously unvaccinated children aged 6 months	ths – 4 years at high risk of severe illness

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