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	SCRIBER	PATIENT:			
Name	9:	Name:			
Ward	:	NHI:			
Fulv	estrant				
Re-a	ATION ussessment required after 6 months equisites (tick boxes where appropriate)				
ا مصط	Prescribed by, or recommended by a medical oncologist, or in accommodate.	ordance with a protocol or guideline that has been endorsed by the Health NZ			
and	Patient has disease progression following prior treatment with metastatic disease	Treatment to be given at a dose of 500 mg monthly following loading doses			
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)					
and	Prescribed by, or recommended by a medical oncologist, or in according Hospital.	ordance with a protocol or guideline that has been endorsed by the Health NZ			
	Treatment remains appropriate and patient is benefitting from and Treatment to be given at a dose of 500 mg monthly and No evidence of disease progression	treatment			

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Signeg	 Date	