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:
Pirfenidone	
INITIATION – idiopathic pulmonary fibrosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by a NZ Hospital.	a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health
Patient has been diagnosed w	ith idiopathic pulmonary fibrosis by a multidisciplinary team including a radiologist
O Forced vital capacity is between	n 50% and 90% predicted
	ed at disease progression (See Notes)
and Pirfenidone is not to be used in	n combination with subsidised nintedanib
O The patient has not prev	iously received treatment with nintedanib
	eceived nintedanib, but discontinued nintedanib within 12 weeks due to intolerance
	eceived nintedanib, but the patient's disease has not progressed (disease progression defined as 10% cted FVC within any 12 month period since starting treatment with nintedanib)
CONTINUATION – idiopathic pulmonary fib Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	rosis
	a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health
	opropriate and patient is benefitting from and tolerating treatment
	n combination with subsidised nintedanib
	ed at disease progression (See Note)
Note: disease progression is defined as a deperiod.	cline in percent predicted FVC of 10% or more within any 12 month

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