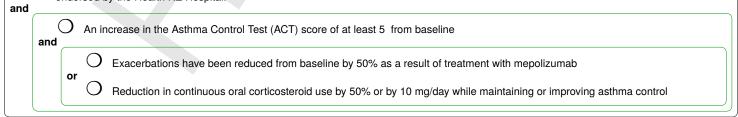
HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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			ATIENT:	
lame:		N	lame:	
/ard:		N	IHI:	
Mepolizumab				
Re-asses	smen	Severe eosinophilic asthma It required after 12 months (tick boxes where appropriate)		
		cribed by, or recommended by a respiratory physician or clinical in rsed by the Health NZ Hospital.	nmunologist, or in accordance with a protocol or guideline that has been	
and	O	Patient must be aged 12 years or older		
and	Ο	Patient must have a diagnosis of severe eosinophilic asthma doc	sumented by a respiratory physician or clinical immunologist	
and	O I	Conditions that mimic asthma eg. vocal cord dysfunction, central airway obstruction, bronchiolitis etc. have been excluded		
and	O Patient has a blood eosinophil count of greater than 0.5 × 10 ^o 9 cells/L in the last 12 months			
	0	Patient must be adherent to optimised asthma therapy including inhaled corticosteroids (equivalent to at least 1000 mcg per day of fluticasone propionate) plus long acting beta-2 agonist, or budesonide/formoterol as part of the single maintenance and reliever therapy regimen, unless contraindicated or not tolerated		
and	or	defined as either documented use of oral corticosteroids fo	corticosteroids in the previous 12 months, where an exacerbation is or at least 3 days or parenteral corticosteroids east the equivalent of 10 mg per day over the previous 3 months	
	and O Treatment is not to be used in combination with subsidised benralizumab			
and	0	Patient has an Asthma Control Test (ACT) score of 10 or less. B and oral corticosteroid dose must be made at the time of applica response to treatment	aseline measurements of the patient's asthma control using the ACT tion, and again at around 52 weeks after the first dose to assess	
and	or	O Patient has not previously received an anti-IL5 biological th	nerapy for their severe eosinophilic asthma	
		O Patient was refractory or intolerant to previous anti-Il and	.5 biological therapy	
		O Patient was not eligible to continue treatment with pr 12 months of commencing treatment	evious anti-IL5 biological therapy and discontinued within	

Prerequisites (tick boxes where appropriate)

O 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.



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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 The patient has trialled and not received adequate benefit from at least one of the following for at least three months (unless contraindicated to all): azathioprine, cyclophosphamide, leflunomide, methotrexate, mycophenolate, or rituximab 		
O The patient has trialled prednisone for a minimum of thr 7.5 mg per day O 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: