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Alimentary Tract and Metabolism

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:
Calcium carbonate	

Prerequisites (tick box where appropriate)

O Only when prescribed for patients unable to swallow calcium carbonate tablets or where calcium carbonate tablets are inappropriate.

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:	

Budesonide

INITIATION – Crohn's disease Prerequisites (tick boxes where appropriate)			
an	O	Mild to moderate ileal, ileocaecal or proximal Crohn's disease	
		O Diabetes	
	or	O Cushingoid habitus	
	or	O Osteoporosis where there is significant risk of fracture	
	or	O Severe acne following treatment with conventional corticosteroid therapy	
	or	O History of severe psychiatric problems associated with corticosteroid treatment	
	or	O History of major mental illness (such as bipolar affective disorder) where the risk of conventional corticosteroid treatment causing relapse is considered to be high	
	or	O Relapse during pregnancy (where conventional corticosteroids are considered to be contraindicated)	
INITIATION – Collagenous and lymphocytic colitis (microscopic colitis) Prerequisites (tick box where appropriate)			
O Patient has a diagnosis of microscopic colitis (collagenous or lymphocytic colitis) by colonoscopy with biopsies			
		Gut Graft versus Host disease (tick box where appropriate)	
Ο	O Patient has gut Graft versus Host disease following allogenic bone marrow transplantation		

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:				Name:
Ward:				NHI:
Budeson	nide	- cor	ntinued	
Re-assess	men	requ	irrhotic autoimmune hepatitis lired after 6 months boxes where appropriate)	
	0	Patie	ent has autoimmune hepatitis*	
and	Ο	Patie	ent does not have cirrhosis	
		Ο	Diabetes	
	or	Ο	Cushingoid habitus	
		Ο	Osteoporosis where there is significant risk of fracture	
	or	Ο	Severe acne following treatment with conventional cortice	osteroid therapy
	or	Ο	History of severe psychiatric problems associated with co	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
		Ο	Relapse during pregnancy (where conventional corticost	eroids are considered to be contraindicated)
	or	0	Adolescents with poor linear growth (where conventional	corticosteroid use may limit further growth)
Note: Indications marked with * are unapproved indications.				
Re-assess	men	requ	non-cirrhotic autoimmune hepatitis nired after 6 months box where appropriate)	
	Freatr	nent	remains appropriate and the patient is benefitting from the	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.

PRESC	RIBER	PATIENT:	
Name:		Name:	
Ward:		NHI:	
Raniti	dine		
INITIA Prereq	FION uisites (tick boxes where appropriate)		
	O For continuation use		
C	O Routine prevention of allergic reactions.		

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:
Omeprazole - Tab dispersible 20 mg	
INITIATION Prerequisites (tick box where appropriate)	
O Only for use in tube-fed patients	

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)

()For patients with chronic hepatic encephalopathy who have not responded to treatment with, or are intolerant to lactulose, or where lactulose is contraindicated

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:
Rifaximin	
INITIATION	
Prerequisites (tick box where appropriate)	

 $m O\,$ For patients with hepatic encephalopathy despite an adequate trial of maximum tolerated doses of lactulose

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

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:
Dulaglutide	
INITIATION Prerequisites (tick box where appropriate)	
O For continuation only	

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:
Liraglutide	
INITIATION	

or	Or	For c	ontinuation use
	and	Ο	Patient has type 2 diabetes
	and	0	Target HbA1c (of 53 mmol/mol or less) has not been achieved despite the regular use of all of the following funded blood glucose lowering agents for a period of least 6 months, where clinically appropriate: empagliflozin, metformin, and vildagliptin
		or	O Patient is Māori or any Pacific ethnicity*
		-	O Patient has pre-existing cardiovascular disease or risk equivalent (see note a)*
		or	O Patient has an absolute 5-year cardiovascular disease risk of 15% or greater according to a validated cardiovascular risk assessment calculator*
		or	O Patient has a high lifetime cardiovascular risk due to being diagnosed with type 2 diabetes during childhood or as a young adult*
		or	O Patient has diabetic kidney disease (see note b)*

Note: * Criteria intended to describe patients at high risk of cardiovascular or renal complications of diabetes.

- a) Pre-existing cardiovascular disease or risk equivalent defined as: prior cardiovascular disease event (i.e. angina, myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, transient ischaemic attack, ischaemic stroke, peripheral vascular disease), congestive heart failure or familial hypercholesterolaemia.
- b) Diabetic kidney disease defined as: persistent albuminuria (albumin:creatinine ratio greater than or equal to 3 mg/mmol, in at least two out of three samples over a 3-6 month period) and/or eGFR less than 60 mL/min/1.73m2 in the presence of diabetes, without alternative cause identified.
- c) Funded GLP-1a treatment is not to be given in combination with (empagliflozin / empagliflozin with metformin hydrochloride) unless receiving (empagliflozin or empagliflozin in combination with metformin hydrochloride) for the treatment of heart failure.

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:		

Empagliflozin; Empagliflozin with metformin hydrochloride

		- heart failure reduced ejection fraction s (tick boxes where appropriate)
ſ	Ċ	Patient has heart failure
	and C and	Patient is in NYHA functional class II or III or IV
		O Patient has a documented left ventricular ejection fraction (LVEF) of less than or equal to 40%
	01	O An ECHO is not reasonably practicable, and in the opinion of the treating practitioner the patient would benefit from treatment
•	and	Patient is receiving concomitant optimal standard funded chronic heart failure treatment

INITIATION – Type 2 Diabetes

Prerequisites (tick boxes where appropriate)

	or	$\overline{\mathbf{O}}$		tinuation use
	or	U F	Patient	has previously had an initial approval for a GLP-1 agonist
		(and	Ор	atient has type 2 diabetes
			or (D Patient is Māori or any Pacific ethnicity*
				D Patient has pre-existing cardiovascular disease or risk equivalent (see note a)*
			or or	Patient has an absolute 5-year cardiovascular disease risk of 15% or greater according to a validated cardiovascular risk assessment calculator*
			or (Patient has a high lifetime cardiovascular risk due to being diagnosed with type 2 diabetes during childhood or as a young adult*
				Patient has diabetic kidney disease (see note b)*
		and		arget HbA1c (of 53 mmol/mol or less) has not been achieved despite the regular use of at least one blood-glucose lowering gent (e.g. metformin, vildagliptin, or insulin) for at least 3 months
No	te: * Cr	riteria i	ntende	d to describe patients at high risk of cardiovascular or renal complications of diabetes.
a)	corona	ry inte	rventio	ascular disease or risk equivalent defined as: prior cardiovascular disease event (i.e. angina, myocardial infarction, percutaneous n, coronary artery bypass grafting, transient ischaemic attack, ischaemic stroke, peripheral vascular disease), congestive heart percholesterolaemia.
b)				ase defined as: persistent albuminuria (albumin:creatinine ratio greater than or equal to 3 mg/mmol, in at least two out of three month period) and/or eGFR less than 60 mL/min/1.73m2 in the presence of diabetes, without alternative cause.
c)	Funded [empagliflozin / empagliflozin with metformin hydrochloride] treatment is not to be given in combination with a funded GLP-1 unless receiving (empagliflozin / empagliflozin with metformin hydrochloride] for the treatment of heart failure.			

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:		
Ursodeoxycholic acid			
INITIATION – Alagille syndrome or progressive familial intrahepatic cholestasis Prerequisites (tick boxes where appropriate)			
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			
Cholestatic liver injury not due to Total Parenteral Nutrition (TF	N) use in adults		
O Treatment with ursodeoxycholic acid may prevent hospital adm	hission or reduce duration of stay		
INITIATION – Primary biliary cholangitis Prerequisites (tick boxes where appropriate) Primary biliary cholangitis confirmed by antimitochondrial antik without raised serum IgM or, if AMA is negative by liver biopsy and Patient not requiring a liver transplant (bilirubin > 100 umol/l; d	body titre (AMA) > 1:80, and raised cholestatic liver enzymes with or ecompensated cirrhosis		
INITIATION – Pregnancy Prerequisites (tick box where appropriate) O Patient diagnosed with cholestasis of pregnancy			
INITIATION – Haematological transplant Prerequisites (tick boxes where appropriate)			
O Patient at risk of veno-occlusive disease or has hepatic impair cell or bone marrow transplantation and O Treatment for up to 13 weeks	ment and is undergoing conditioning treatment prior to allogenic stem		
INITIATION – Total parenteral nutrition induced cholestasis Prerequisites (tick boxes where appropriate)			
O Paediatric patient has developed abnormal liver function as inc and O Liver function has not improved with modifying the TPN compo			

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:
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 AALL	.1732 trial
O The patient has leukaemia/lymphoma and is receiving inotuzu	mab ozogamicin

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:				
Methylnaltrexone bromide					
INITIATION – Opioid induced constipation					
Prerequisites (tick boxes where appropriate)					

() The	patient is receiving palliative care		
and	0	Oral and rectal treatments for opioid induced constipation are ineffective		
	or ()	Oral and rectal treatments for opioid induced constipation are unable to be tol	erated	

INITIATION – Opioid induced constipation outside of palliative care

Re-assessment required after 14 days

Prerequisites (tick boxes where appropriate)

and and and

Individual has opioid induced constipation

Oral and rectal treatments for opioid induced constipation, including bowel-cleansing preparations, are ineffective or inappropriate

Mechanical bowel obstruction has been excluded

I confirm that the above details are correct:

Signed: Date:

 \bigcirc

and ()

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:
sodium picosulfate	
INITIATION Prerequisites (tick boxes where appropriate)	

The patient is a child with problematic constipation despite an adequate trial of other oral pharmacotherapies including macrogol where practicable

The patient would otherwise require a high-volume bowel cleansing preparation

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:		

Betaine

()

(
	ATIO			a factor de la contra
				quired after 12 months
Prer	equis	ites	(tick	k boxes where appropriate)
and			cribe Iospi	ed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health ital.
	(and	О	The	e patient has a confirmed diagnosis of homocystinuria
		or	0	A cystathionine beta-synthase (CBS) deficiency
			\bigcirc	A 5,10-methylene-tetrahydrofolate reductase (MTHFR) deficiency
		or	О	A disorder of intracellular cobalamin metabolism
	and	О	An	appropriate homocysteine level has not been achieved despite a sufficient trial of appropriate vitamin supplementation
	TINU. ssess			quired 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.

The treatment remains appropriate and the patient is benefiting from 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:			
_evocarnitine				

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:		
Sodium phenylbutyrate			
INITIATION Re-assessment required after 12 months Prerequisites (tick box where appropriate)			
Prescribed by, or recommended by a metabolic physician, or in acconditional NZ Hospital.	rdance with a protocol or guideline that has been endorsed by the Health		

For the chronic management of a urea cycle disorder involving a deficiency of carbamylphosphate synthetase, ornithine transcarbamylase or argininosuccinate synthetase

CONTINUATION

()

()

and \bigcirc

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

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.

The treatment remains appropriate and the patient is benefiting from 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:
Biotin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a metabolic physician or metabolic disorders dietitian, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:		
Pyridoxal-5-phosphate			

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:	

Galsulfase

and

Re-a		nent required after 12 months es (tick boxes where appropriate)
(and		escribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health Z Hospital.
	and	D The patient has been diagnosed with mucopolysaccharidosis VI
		O Diagnosis confirmed by demonstration of N-acetyl-galactosamine-4-sulfatase (arylsulfatase B) deficiency confirmed by either enzyme activity assay in leukocytes or skin fibroblasts
		or O Detection of two disease causing mutations and patient has a sibling who is known to have mucopolysaccharidosis VI
\subseteq		
Re-a		TION nent required after 12 months es (tick boxes where appropriate)
(and		escribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health Z Hospital.
	(and) The treatment remains appropriate for the patient and the patient is benefiting from treatment
	(Patient has not had severe infusion-related adverse reactions which were not preventable by appropriate pre-medication and/or adjustment of infusion rates
	and (Patient has not developed another life threatening or severe disease where the long term prognosis is unlikely to be influenced by Enzyme Replacement Therapy (ERT)

Patient has not developed another medical condition that might reasonably be expected to compromise a response to ERT

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:	

Alglucosidase Alfa

INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) 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 patient is aged up to 24 months at the time of initial application and has been diagnosed with infantile Pompe disease and () Diagnosis confirmed by documented deficiency of acid alpha-glucosidase by prenatal diagnosis using chorionic villus biopsies and/or cultured amniotic cells or Documented deficiency of acid alpha-glucosidase, and urinary tetrasaccharide testing indicating a diagnostic elevation of glucose tetrasaccharides or Documented deficiency of acid alpha-glucosidase, and documented molecular genetic testing indicating a disease-causing mutation in the acid alpha-glucosidase gene (GAA gene) or Documented urinary tetrasaccharide testing indicating a diagnostic elevation of glucose tetrasaccharides, and molecular genetic testing indicating a disease-causing mutation in the GAA gene and) Patient has not required long-term invasive ventilation for respiratory failure prior to starting enzyme replacement therapy (ERT) and () Patient does not have another life-threatening or severe disease where the prognosis is unlikely to be influenced by ERT or might be reasonably expected to compromise a response to ERT

Alglucosidase alfa to be administered at doses no greater than 20 mg/kg every 2 weeks

CONTINUATION

and

	Re-assessment required after 12 months		
Prei	equis	sites	(tick boxes where appropriate)
and			bribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.
	and	Ο	The treatment remains appropriate for the patient and the patient is benefiting from treatment
	and	Ο	Alglucosidase alfa to be administered at doses no greater than 20 mg/kg every 2 weeks
		0	Patient has not had severe infusion-related adverse reactions which were not preventable by appropriate pre-medication and/or adjustment of infusion rates
	and	Ο	Patient has not developed another life threatening or severe disease where the long term prognosis is unlikely to be influenced by ERT
	and	Ο	Patient has not developed another medical condition that might reasonably be expected to compromise a response to ERT
	and	0	There is no evidence of life threatening progression of respiratory disease as evidenced by the needed for > 14 days of invasive ventilation
	and	0	There is no evidence of new or progressive cardiomyopathy

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:	

Idursulfase

Re-a		men	t required after 24 weeks (tick boxes where appropriate)
(and	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.		
	unu	or	 Diagnosis confirmed by demonstration of iduronate 2-sulfatase deficiency in white blood cells by either enzyme assay in cultured skin fibroblasts Detection of a disease causing mutation in the iduronate 2-sulfatase gene
	and (and	0	Patient is going to proceed with a haematopoietic stem cell transplant (HSCT) within the next 3 months and treatment with idursulfase would be bridging treatment to transplant
	(and (0 0	Patient has not required long-term invasive ventilation for respiratory failure prior to starting Enzyme Replacement Therapy (ERT) Idursulfase to be administered for a total of 24 weeks (equivalent to 12 weeks pre- and 12 weeks post-HSCT) at doses no greater than 0.5 mg/kg every week

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:

Laronidase

	ATIO ssess		it required after 24 weeks	
Prer	equis	ites	(tick boxes where appropriate)	
(and	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	0	The patient has been diagnosed with Hurler Syndrome (mucopolysacchardosis I-H)	
	O Detection of two disease causing mutations in the alpha-L-iduronidase gene and patient has a sibling who is known to ha Hurler syndrome		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			
	and	0	Patient has not required long-term invasive ventilation for respiratory failure prior to starting Enzyme Replacement Therapy (ERT)	
		\bigcirc	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	

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:	

Taliglucerase alfa

INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) 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 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 and 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 and \bigcirc Patient has haematological complications of Gaucher disease or Patient has skeletal complications of Gaucher disease or Patient has significant liver dysfunction or hepatomegaly attributable to Gaucher disease or Patient has reduced vital capacity from clinically significant or progressive pulmonary disease due to Gaucher disease or Patient is a child and has experienced growth failure with significant decrease in percentile linear growth over a 6-12 month period and 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) Note: Indication marked with * is an unapproved indication CONTINUATION Re-assessment required after 3 years Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a metabolic physician or any relevant practitioner on the recommendation of a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and () 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 and 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 and Patient has not developed another medical condition that might reasonably be expected to compromise a response to ERT

Patient is adherent with regular treatment and 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)

and

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:

Sapropterin dihydrochloride

INITIATION Re-assessment required after 1 month Prereguisites (tick boxes 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.
O Patient has phenylketonuria (PKU) and is pregnant or actively planning to become pregnant
and O Treatment with sapropterin is required to support management of PKU during pregnancy and
O Sapropterin to be administered at doses no greater than a total daily dose of 20 mg/kg
O Sapropterin to be used alone or in combination with PKU dietary management
Total treatment duration with sapropterin will not exceed 22 months for each pregnancy (includes time for planning and becoming pregnant) and treatment will be stopped after delivery
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes 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
 Following the initial one-month approval, the patient has demonstrated an adequate response to a 2 to 4 week trial of sapropterin with a clinically appropriate reduction in phenylalanine levels to support management of PKU during pregnancy On subsequent renewal applications, the patient has previously demonstrated response to treatment with sapropterin and maintained adequate phenylalanine levels to support management of PKU during pregnancy
and
O Patient continues to be pregnant and treatment with sapropterin will not continue after delivery or
O Patient is actively planning a pregnancy and this is the first renewal for treatment with sapropterin or
O Treatment with sapropterin is required for a second or subsequent pregnancy to support management of their PKU during pregnancy
and O Sapropterin to be administered at doses no greater than a total daily dose of 20 mg/kg and O Sapropterin to be used alone or in combination with PKU dietary management and O Total treatment duration with sapropterin will not exceed 22 months for each pregnancy (includes time for planning and becoming
pregnant) and treatment will be stopped after delivery

and

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:
Carglumic Acid	
INITIATION Prerequisites (tick box where appropriate)	

()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.

O For the acute in-patient treatment of organic acidaemias as an alternative 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) O Prescribed by, or recommended by a metabolic physician, or in acco NZ Hospital. and O The patient has a suspected inborn error of metabolism that may res	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 acco NZ Hospital. and O The patient has a confirmed diagnosis of an inborn error of me	ordance with a protocol or guideline that has been endorsed by the Health etabolism that responds to coenzyme Q10 supplementation
O The treatment remains appropriate and the patient is benefitin	g from 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:
Riboflavin	
INITIATION Re-assessment required after 6 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a metabolic physician or neurolo by the Health NZ Hospital. and O 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) O Prescribed by, or recommended by a metabolic physician or neurolo by the Health NZ Hospital. and O The patient has a confirmed diagnosis of an inborn error of me and O The treatment remains appropriate and the patient is benefitin	

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: Ward: NHI: Taurine NHI: INITIATION Re-assessment required after 6 months Prerequisites (tick box where appropriate) 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 patient has a suspected specific mitochondrial disorder that may respond to taurine supplementation CONTINUATION Re-assessment required after 24 months Prerequisites (tick boxes where appropriate) 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 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 O The patient has a confirmed diagnosis of a specific mitochondrial disorder which responds to taurine supplementation	PRESCRIBER	PATIENT:
Taurine INITIATION Re-assessment required after 6 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 O The patient has a suspected specific mitochondrial disorder that 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 accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and 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 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 O The patient has a confirmed diagnosis of a specific mitochondrial disorder which responds to taurine supplementation	Name:	Name:
INITIATION Re-assessment required after 6 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 O The patient has a suspected specific mitochondrial disorder that 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 accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and 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 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 O The patient has a confirmed diagnosis of a specific mitochondrial disorder which responds to taurine supplementation	Ward:	NHI:
Re-assessment required after 6 months Prerequisites (tick box where appropriate) 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. The patient has a suspected specific mitochondrial disorder that may respond to taurine supplementation CONTINUATION Re-assessment required after 24 months Prerequisites (tick boxes where appropriate) 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. The patient has a suspected specific mitochondrial disorder that may respond to taurine supplementation CONTINUATION Re-assessment required after 24 months Prerequisites (tick boxes where appropriate) 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 patient has a confirmed diagnosis of a specific mitochondrial disorder which responds to taurine supplementation	Taurine	
Re-assessment required after 24 months Prerequisites (tick boxes 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 O The patient has a confirmed diagnosis of a specific mitochondrial disorder which responds to taurine supplementation	Re-assessment required after 6 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a metabolic physician, or in acco NZ Hospital. and	
O The treatment remains appropriate and the patient is benefiting from 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	ł	PATIENT:
Name:		Name:
Ward:	rd: NHI:	
Trientine		
INITIATION Prerequisites	s (tick boxes where appropriate)	
and	Patient has confirmed Wilson disease	
and	Treatment with D-penicillamine has been trialled and discontinune not received sufficient benefit	ed because the person has experienced intolerable side effects or has
	O 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	

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	2:	Name:
Ward	:	NHI:
Сор	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	
	O Treatment is recommended by a National Burns Unit specialis	t

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

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	·	Name:
Ward:		NHI:
Sele	nium	
	ATION – Moderate to severe burns ssessment required after 3 months	
Prere	equisites (tick boxes where appropriate)	
	O Patient has been hospitalised with moderate to severe burns	
	O Treatment is recommended by a National Burns Unit specialis	t

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:				
Sodium hyaluronate					

INITIATION

Prerequisites (tick box where appropriate)

()Prescribed by, or recommended by an otolaryngologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

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:				
Mult	Multivitamins - Cap							
INITIATION Prerequisites (tick boxes where appropriate)								
		0	Patient has cystic fibrosis with pancreatic insufficiency					
	or or	Ο	Patient is an infant or child with liver disease or short gut synd	rome				
		0	Patient has severe malabsorption syndrome					

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:
Multivitamins – Powder	
INITIATION Prerequisites (tick box where appropriate)	
O Patient has inborn errors of metabolism	

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:
Multivitamin and mineral supplement	
INITIATION Re-assessment required after 3 months Prerequisites (tick boxes where appropriate)	
O Burn size is greater than 15% of total body surface area or O Burn size is greater than 10% of BSA for mid-dermal or or O Nutritional status prior to admission or dietary intake is p	deep dermal burns

or

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:
Multivitamin renal	
INITIATION Prerequisites (tick boxes where appropriate)	

 \bigcirc The patient has chronic kidney disease and is receiving either peritoneal dialysis or haemodialysis

The patient has chronic kidney disease grade 5, defined as patient with an estimated glomerular filtration rate of < 15 ml/min/1.73m² body surface area (BSA)

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:	
Name	ə:		Name:	
Ward	:		NHI:	
Alph	a to	сор	oheryl acetate	
			Cystic fibrosis (tick boxes where appropriate)	
	and	0	Cystic fibrosis patient	
		or	 Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) The other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically the patient 	inappropriate for
	equis	ites	Osteoradionecrosis (tick box where appropriate) he treatment of osteoradionecrosis	
			Other indications (tick boxes where appropriate)	
	and	0 0	Infant or child with liver disease or short gut syndrome Requires vitamin supplementation	
	and	or	 Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplements (Vitabdeck) The other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically patient 	inappropriate for

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:		

Alpha tocopheryl

INITIATION – Cystic fibrosis Prerequisites (tick boxes where appropriate)			
	(and	С	Cystic fibrosis patient
		or	O Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck)
			O The other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate for the patient
			Osteoradionecrosis tick box where appropriate)
O For the treatment of osteoradionecrosis			
			other indications tick boxes where appropriate)
	(and	С	Infant or child with liver disease or short gut syndrome
	and (C	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

Blood and Blood Forming 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.

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		

Epoetin beta

and) Patie	nt in chronic renal failure
and) Haer	noglobin is less than or equal to 100g/L
	an	 Patient does not have diabetes mellitus Glomerular filtration rate is less than or equal to 30ml/min
	or an	 Patient has diabetes mellitus Glomerular filtration rate is less than or equal to 45ml/min

INITIATION – myelodysplasia*

and

and

and

and

and

Re-assessment required after 12 months

 $\label{eq:precession} \textbf{Prerequisites} \ (tick \ boxes \ where \ appropriate)$

\bigcirc	Patient has a confirmed diagnosis of myelodysplasia	(MDS)
and		

Has had symptomatic anaemia with haemoglobin < 100g/L and is red cell transfusion-dependent

O Patient has very low, low or intermediate risk MDS based on the WHO classification-based prognostic scoring system for myelodysplastic syndrome (WPSS)

 $\odot~$ Other causes of anaemia such as B12 and folate deficiency have been excluded

 ${\sf O}\,$ Patient has a serum epoetin level of < 500 IU/L

The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week

CONTINUATION – myelodysplasia*

Re-assessment required after 2 months
Prerequisites (tick boxes where appropriate)
O
The patient's transfusion requirement continues to be reduced with epoetin treatment
and

O 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

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:
Epoetin beta - continued	
INITIATION – all other indications Prerequisites (tick boxes where appropriate)	
Haematologist	
O For use in patients where blood transfusion is not a viable trea	atment alternative
and *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:	

Epoetin alfa

		(tick boxes where appropriate) Patient in chronic renal failure	
and (and	J ⊦	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	Patient has diabetes mellitus and O Glomerular filtration rate is less than or equal to 45ml/min	
	or (O Patient is on haemodialysis or peritoneal dialysis	

INITIATION – myelodysplasia*

and

and

and

and

and

and

Re-assessment required after 2 months

Prerequisites (tick boxes where appropriate)

(\bigcirc	Patient has a co	nfirmed diagnosis o	of myelodysplasia	(MDS
	\sim	i alloint hao a oo	mininea alagnoolo c	n myclouyopiuolu	

Has had symptomatic anaemia with haemoglobin < 100g/L and is red cell transfusion-dependent

\bigcirc	Patient has very low, low or intermediate risk MDS based on the WHO classification-based prognostic scoring system for myelodysplastic
	syndrome (WPSS)

 ${\cal J}\,$ Other causes of anaemia such as B12 and folate deficiency have been excluded

 ${\sf O}$ Patient has a serum epoetin level of < 500 IU/L

The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week

CONTINUATION – myelodysplasia*

Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

O The patient's transfusion requirement continues to be reduced with epoetin treatment and

O 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

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:			
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	alternative			
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.

PRES	SCR	BER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Apro	otin	in		
INIT Prer			(tick boxes where appropriate)	
and	С		cribed by, or recommended by a cardiac anaesthetist, or in acco lospital.	ordance with a protocol or guideline that has been endorsed by the Health
		0	Paediatric patient undergoing cardiopulmonary bypass proced	lure
	or	Ο	Adult patient undergoing cardiac surgical procedure where the effects of the drug	e significant risk of massive bleeding outweighs the potential adverse

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:			Name:		
Ward:					NHI:
Eltro	omb	ора	g		
Re-a	isses	smer	nt requ	athic thrombocytopenic purpura - post-splenectomy uired after 6 weeks boxes where appropriate)	
and	С	Pres Hosp		by, or recommended by a haematologist, or in accordance	e with a protocol or guideline that has been endorsed by the Health NZ
	and	C	Patie	ent has had a splenectomy	
	and	C t	Two	immunosuppressive therapies have been trialled and faile	d after therapy of 3 months each (or 1 month for rituximab)
		or	0		per microlitre and has evidence of significant mucocutaneous bleeding
		or	0	Patient has a platelet count of less than or equal to 20,0	00 platelets per microlitre and has evidence of active bleeding
			\bigcirc	Patient has a platelet count of less than or equal to 10,0	00 platelets per microlitre
and		Pres Hosp	cribed ital.	box where appropriate) by, or recommended by a haematologist, or in accordanc t requires eltrombopag treatment as preparation for splen	e with a protocol or guideline that has been endorsed by the Health NZ
Re-a	isses	smer	nt requ	diopathic thrombocytopenic purpura - post-splenecto uired after 12 months box where appropriate)	my
	С	Pres Hosp		by, or recommended by a haematologist, or in accordance	e with a protocol or guideline that has been endorsed by the Health NZ
and (Note) Re	treat	ment i	t has obtained a response (see Note) from treatment durin s required reatment is defined as a platelet count of > 30,000 platele	ng the initial approval or subsequent renewal periods and further ts per microlitre
Re-a	isses	smer	nt requ	athic thrombocytopenic purpura contraindicated to sp uired after 3 months poxes where appropriate)	lenectomy
and	С	Pres Hosp		by, or recommended by a haematologist, or in accordance	e with a protocol or guideline that has been endorsed by the Health NZ
	and	C	Patie	ent has a significant and well-documented contraindication	to splenectomy for clinical reasons
	and	Ο	Two	immunosuppressive therapies have been trialled and faile	d after therapy of 3 months each (or 1 month for rituximab)
		or	0	Patient has immune thrombocytopenic purpura* with a p	latelet count of less than or equal to 20,000 platelets per microliter
			0	Patient has immune thrombocytopenic purpura* with a p mucocutaneous bleeding	latelet count of 20,000 to 30,000 platelets per microlitre and significant

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:
Eltrombopag - continued	
CONTINUATION – idiopathic thrombocytopenic purpura contraindicated Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	e with a protocol or guideline that has been endorsed by the Health NZ ns e initial approval period elets per microlitre on treatment
Hospital. and Two immunosuppressive therapies have been trialled and faile and O Patient has severe aplastic anaemia with a platelet coun	
and Hospital.	e with a protocol or guideline that has been endorsed by the Health NZ t 20,000 platelets per microlitre above baseline during the initial approval luring the initial approval period

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

and ()

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:	
Emicizumab		

INITIATION - Severe Haemophilia A with or without FVIII inhibitors 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

Patient has severe congenital haemophilia A with a severe bleeding phenotype (endogenous factor VIII activity less than or equal to 2%)

Emicizumab is to be administered at a dose of no greater than 3 mg/kg weekly for 4 weeks followed by the equivalent of 1.5 mg/kg weekly

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:
Idarucizumab	

INITIATION

Prerequisites (tick box where appropriate)

()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

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:
Moroctocog alfa [Recombinant factor VIII]	

INITIATION

Prerequisites (tick box where appropriate)

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 ()

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:
Octocog alfa [Recombinant factor VIII] (Advate)	

INITIATION

Prerequisites (tick box where appropriate)

()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

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:
Octocog alfa [Recombinant factor VIII] (Kogenate FS)	

INITIATION

Prerequisites (tick box where appropriate)

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 ()

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:
Nonacog gamma	

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

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:
Rurioctocog alfa pegol [Recombinant factor VIII]	

INITIATION

Prerequisites (tick box where appropriate)

For patients with haemophilia A receiving prophylaxis treatment. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group ()

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:
Eftrenonacog alfa	

INITIATION

Prerequisites (tick box where appropriate)

For patients with haemophilia B receiving prophylaxis treatment. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group ()

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)

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 ()

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:
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

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:
Bivalirudin	
INITIATION Prerequisites (tick boxes where appropriate)	
O For use in heparin-induced thrombocytopaenia, heparin resistance or heparin intolerance	
O For use in patients undergoing endovascular procedures	

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 or heparin intolerance

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:
Defibro	tide	
INITIATION Prerequisites (tick box where appropriate)		
0	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	Patient has moderate or severe sinusoidal obstruction syndrome as	a result of chemotherapy or regimen-related toxicities

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

and ()

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:
Lysine acetylsalicylate	
Prerequisites (tick boxes where appropriate)	

 \bigcirc For use when an immediate antiplatelet effect is required prior to an urgent interventional neuro-radiology or interventional cardiology procedure

Administration of oral aspirin would delay the procedure

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:
Eptifibatide		
or For use in patients with	acute coronary syndromes undergoing	g percutaneous coronary intervention onary thrombus on coronary angiography

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:	ne: Name:		
Ward:	NHI:		
Ticagre	lor		
INITIATIO Prerequi	DN sites (tick box where appropriate) Restricted to treatment of acute coronary syndromes specifically for patients who have recently (within the last 60 days) been diagnosed with an ST-elevation or a non-ST-elevation acute coronary syndrome, and in whom fibrinolytic therapy has not been given in the last 24 hours and is not planned		
Re-asses	DN – thrombosis prevention neurological stenting ssment required after 12 months sites (tick boxes where appropriate)		
	O Patient has had a neurological stenting procedure* in the last 60 days or O Patient is about to have a neurological stenting procedure performed*		
and	O Patient has demonstrated clopidogrel resistance using the P2Y12 (VerifyNow) assay or another appropriate platelet function assay and requires antiplatelet treatment with ticagrelor		
	O Clopidogrel resistance has been demonstrated by the occurrence of a new cerebral ischemic event or O Clopidogrel resistance has been demonstrated by the occurrence of transient ischemic attack symptoms referable to the stent.		
Re-asses	JATION – thrombosis prevention neurological stenting sment required after 12 months sites (tick boxes where appropriate)		
and	Patient is continuing to benefit from treatment Treatment continues to be clinically appropriate		
Re-asses	DN – Percutaneous coronary intervention with stent deployment ssment required after 12 months sites (tick boxes where appropriate)		
and	 Patient has undergone percutaneous coronary intervention Patient has had a stent deployed in the previous 4 weeks 		
and			
	DN – Stent thrombosis sites (tick box where appropriate) Patient has experienced cardiac stent thrombosis whilst on clopidogrel		
	DN – Myocardial infarction ssment required after 1 week		
	sites (tick box where appropriate) For short term use while in hospital following ST-elevated myocardial infarction		
l confirm tl	hat 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:

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

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	BER	PATIENT:
lame:		Name:
Vard:		NHI:
Plerixafo	r	
Re-assess Prerequis	ites (ti	utologous stem cell transplant required after 3 days tick boxes where appropriate)
	lospita	ibed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ al.
and (and		Patient is to undergo stem cell transplantation Patient has not had a previous unsuccessful mobilisation attempt with plerixafor
		Patient is undergoing G-CSF mobilisation and O Has a suboptimal peripheral blood CD34 count of less than or equal to 10 × 10 ⁶ /L on day 5 after 4 days of G-CSF or C Efforts to collect > 1 × 10 ⁶ CD34 cells/kg have failed after one apheresis procedure
	or	O Patient is undergoing chemotherapy and G-CSF mobilisation and $ \begin{array}{c} $

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:			
Pegfilgrastim				

INITIATION

Prerequisites (tick box where appropriate)

O For prevention of neutropenia in patients undergoing high risk chemotherapy for cancer (febrile neutropenia risk greater than or equal to 5%*) Note: *Febrile neutropenia risk greater than or equal to 5% after taking into account other risk factors as defined by the European Organisation for Research and Treatment of Cancer (EORTC) guidelines

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:
Filgrastim	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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

Cardiovascular 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.

PRES	CRI	BER		PATIENT:
Name	:			Name:
Ward:				NHI:
Capt	opr	ril - C	Dral liq 5 mg per ml	
INITI Prere			(tick boxes where appropriate)	
	_	Ο	For use in children under 12 years of age	
	or	Ο	For use in tube-fed patients	
	or	0	For management of rebound transient hypertension following	cardiac surgery

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	SCRIB	ER			PATIENT:
Name	e:				Name:
Ward	:				NHI:
Sacı	ubitri	۱w	ith v	alsartan	
	IATION equisi		(tick I	poxes where appropriate)	
	(and	С	Patie	ent has heart failure	
			Ο	Patient is in NYHA/WHO functional class II	
		or	Ο	Patient is in NYHA/WHO functional class III	
		or	Ο	Patient is in NYHA/WHO functional class IV	

and			
	or	Ο	Patient has a documented left ventricular ejection fraction (LVEF) of less than or equal to 35%
		Ο	An ECHO is not reasonably practical, and in the opinion of the treating practitioner the patient would benefit from treatment
and (С	Patie	nt is receiving concomitant optimal standard chronic heart failure treatments

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

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:
Ajmaline	

Prerequisites (tick box where appropriate)

()Prescribed by, or recommended by a cardiologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

PRES	CRIB	ER		PATIENT:
Name	:			Name:
Ward:				NHI:
Ivabı	radir	ne		
INITI Prere			(tick boxes where appropriate)	
	(and	0	Patient is indicated for computed tomography coronary anglog	yraphy
		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	

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	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Nicardipine hydrochloride	

Prer	equ	isites	(tick boxes where appropriate)
and	0		cribed by, or recommended by an anaesthetist, intensivist, cardiologist or paediatric cardiologist, or in accordance with a protocol or eline that has been endorsed by the Health NZ Hospital.
		Ο	Patient has hypertension requiring urgent treatment with an intravenous agent
	or	Ο	Patient has excessive ventricular afterload
	or	0	Patient is awaiting or undergoing cardiac surgery using cardiopulmonary bypass

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:
Eple	reno	ne			
	ATION equisi		(tick t	poxes where appropriate)	
	(and	С	Patie	ent has heart failure with ejection fraction less than 40%	
			Ο	Patient is intolerant to optimal dosing of spironolactone	
	or		0	Patient has experienced a clinically significant adverse e	ffect while on optimal dosing of spironolactone

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:				
Telventen					

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 practitioner on the recommendation of a renal physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Patient has a confirmed diagnosis of autosomal dominant polycystic kidney disease and O Patient has an estimated glomerular filtration rate (eGFR) of greater than or equal to 25 ml/min/1.73 m² at treatment initiation or O or Patient's disease is rapidly progressing, with a decline in eGFR of greater than or equal to 5 mL/min/1.73 m² within one-year or O Patient's disease is rapidly progressing, with an average decline in eGFR of greater than or equal to 2.5 mL/min/1.73 m² per year over a five-year period

CONTINUATION – autosomal dominant polycystic kidney disease Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a renal physician or any relevant practitioner on the recommendation of a renal physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and Patient has not developed end-stage renal disease, defined as an eGFR of less than 15 mL/min/1.73 m² Patient has not undergone a kidney transplant

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:

Rosuvastatin

NITIATION – cardiovascular disease risk Prerequisites (tick boxes where appropriate)		
	O Patient is considered to be at risk of cardiovascular disease and O Patient is Māori or any Pacific ethnicity	
or	Patient has a calculated risk of cardiovascular disease of at least 15% over 5 years and LDL cholesterol has not reduced to less than 1.8 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or simvastatin	
	- familial hypercholesterolemia es (tick boxes where appropriate)	
and	 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 es (tick boxes where appropriate)	
	or O Patient has proven coronary artery disease (CAD) or O Patient has proven peripheral artery disease (PAD) or O Patient has experienced an ischaemic stroke	
and	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 es (tick boxes where appropriate)	
and	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	

simvastatin

LDL cholesterol has not reduced to less than 1.0 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or

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:			
Levosimendan				
INITIATION – Heart transplant Prerequisites (tick boxes where appropriate) O For use as a bridge to heart transplant, in patients who have boots or O For the treatment of heart failure following heart transplant	been accepted for 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. and				

O For the treatment of severe acute decompensated heart failure that is non-responsive to dobutamine

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:

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:
Hyd	Hydralazine hydrochloride - Tab 25 mg			
INITIATION Prerequisites (tick boxes where appropriate)			(tick boxes where appropriate)	
		Ο	For the treatment of refractory hypertension	
	or	0	For the treatment of heart failure, in combination with a nitrate and/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.

PRESCR	IBER	PATIENT:
Name:		Name:
Ward:		NHI:
bosenta	an	
Re-asse	ON – PAH monotherapy ssment required after 6 months isites (tick boxes where appropriate) Prescribed by, or recommended by a respiratory specialist, cardiolog a respiratory specialist, cardiologist or rheumatologist, or in accordan Hospital.	gist, rheumatologist or any relevant practitioner on the recommendation of nce with a protocol or guideline that has been endorsed by the Health NZ
an	O PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical cl	

		O PAH has been confirmed by right heart catheterisation
		A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)
		${ m O}$ A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg
		D Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵)
		O 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**
	or C	 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
	or or	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
	С	 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
	С	 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
Ind	С	 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 second se
Ind	or C and	 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 Bosentan is to be used as PAH monotherapy O Patient has experienced intolerable side effects on sildenafil
Ind	or C and	 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 Bosentan is to be used as PAH monotherapy
Ind	or and	 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 Bosentan is to be used as PAH monotherapy Patient has experienced intolerable side effects on sildenafil

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:
bosentan - continu	led
O Prescribed	
Patie and PAH and	nt has pulmonary arterial hypertension (PAH)* 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
and an an an or or or or or or or or or	 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⁻⁵)

Signed: Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
bosentan - continued	
INITIATION – PAH triple therapy Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a respiratory specialist, cardiolog a respiratory specialist, cardiologist or rheumatologist, or in accordation a respiratory specialist, cardiologist or rheumatologist, or in accordation to the triple therapy and and Patient has pulmonary arterial hypertension (PAH)* and PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical cand and PAH is in New York Heart Association/World Health Organization and PAH is in New York Heart Association/World Health Organization and PAH has been confirmed by right heart catheteris and A mean pulmonary artery pressure (PAPm) great and PH has been demonstrated to be non-respication to 20° PAH has been demonstrated to be non-respication to 20° Patient has not experienced an acceptable or risk stratification tool** O Patient has palliated single ventricle congenital heat disorders including severe chronic neonatal lung diseases or O Patient is a child with PAH secondary to congenital heat disorders including severe chronic neonatal lung diseases or O Patient is to be used as part of PAH triple therapy and O P	ation (NYHA/WHO) functional class II, III or IV sation ter than 20 mmHg (unless peri Fontan repair) ess than or equal to 15 mmHg bod Units or greater than 160 International Units (dyn s cm ⁻⁵) ponsive in vasoreactivity assessment using iloprost or nitric oxide, as or PAH (see note below for link to these guidelines) † response to calcium antagonist treatment, according to a validated itable or drug-associated type at disease or PAH due to idiopathic, congenital or developmental lung se isease and elevated pulmonary pressures or a major complication of the y/venous filling pressures ass IV ast three months and has not experienced an acceptable response to
)

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			
	UATION ssment required after 2 years isites (tick box where appropriate)			
O Prescribed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation a respiratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health N Hospital.				
and	Patient is continuing to derive benefit from bosentan treatment acco	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.

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:

Ambrisentan

	INITIATION – PAH monotherapy Re-assessment required after 6 months			
Prer	equis	ites (t	ick bo	ixes where appropriate)
(and	а		ratory	by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of or specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
	(and	O f	Patier	t has pulmonary arterial hypertension (PAH)
	(and	O f	PAH i	s in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications
	(and	O f	PAH i	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	O A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)
			and	m O 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 ⁻⁵)
				O 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	0	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
			О	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	\bigcirc	Ambrisentan is to be used as PAH monotherapy
			or	O Patient has experienced intolerable side effects with both sildenafil and bosentan
				O Patient has an absolute contraindication to sildenafil and an absolute or relative contraindication to bosentan (e.g. due to current use of a combined oral contraceptive or liver disease)
			or	O Patient is a child with idiopathic PAH or PAH secondary to congenital heart disease
		\square	-	

PRES	CRIBEF	2		PATIENT:
Name:				Name:
Ward:				NHI:
Ambr	isenta	an -	con	tinued
Re-as Prere	sessme quisite Pre a re	ent re s (tic scrib espira spital Pa	equire k bo ed b atory atient	al therapy ed after 6 months xes where appropriate) 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 has pulmonary arterial hypertension (PAH) in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
			and and and	 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 Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm⁻⁵) 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
	o o and	C	о Э 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 Fontan circulation requiring the minimising of pulmonary/venous filling pressures
		Ind		Ambrisentan is to be used as PAH dual therapy 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**
	a	nd	or	Patient has tried PAH dual therapy including bosentan and has experienced intolerable side effects on bosentan Patient is presenting in NYHA/WHO functional class III or IV, and in the opinion of the treating clinician would benefit to the initial dual therapy.
			and	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)

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:	ame: Name:		
Ward:	NHI:		
Ambrisentan	- continued		
Re-assessment r Prerequisites (ti O Prescri a respin Hospita and			
and	Patient has pulmonary arterial hypertension (PAH)		
and	PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV		
or or	 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 Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm⁻⁶) and 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) † Or 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 		
and (and	Fontan circulation requiring the minimising of pulmonary/venous filling pressures		
	O Patient is on the lung transplant list Or 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** Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario 		

Signed: Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Ambrisentan - continued	
	pist, rheumatologist or any relevant practitioner on the recommendation of ince with a protocol or guideline that has been endorsed by the Health NZ int according to a validated PAH risk stratification tool**
Note: † The European Respiratory Journal Guidelines can be found here: <u>diagnosis and treatment of pulmonary hypertension PAH</u> ** the requirement to use a validated risk stratification tool to determine ins Determining insufficient response in children does not require use of a validat currently no such validated tools exist for PAH risk stratification in children.	ufficient response applies to adults.

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 (Vedafil)

	(tick boxes where appropriate) Patient has Raynaud's phenomenon			
and	Patient has severe digital ischaemia (defined as severe pain requiring hospital admission or with a high likelihood of digital ulceration; digital ulcers; or gangrene)			
and	Patient is following lifestyle management (proper body insulation, avoidance of cold exposure, smoking cessation support, avoidance of sympathomimetic drugs)			
and	Patient has persisting severe symptoms despite treatment with calcium channel blockers and nitrates (unless contraindicated or not tolerated)			
INITIATION – tablets Pulmonary arterial hypertension Prerequisites (tick boxes where appropriate)				

O Prescribed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

nd	\bigcirc	Patient has pulmonary arterial hypertension (PAH)*		
	and			
	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		
		O PAH is confirmed by right heart catheterisation		
		and A mean pulmonary artery pressure (PAPm) of greater than 20 mmHg		
		and O A pulmonary capillary wedge pressure (PCWP) that is less than or equal to 15 mmHg and		
		O Pulmonary vascular resistance (PVR) of at least 2 Wood Units or at least 160 International Units (dyn s cm ⁻⁵) and		
		O 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) †		
		or O Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**		
		or 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 severe chronic neonatal lung disease		
	or	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		

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	ER		PATIENT:
Name	e:			Name:
Ward:	:			NHI:
silde	enafi	I (V	edafil) - continued	
			ablets other conditions (tick boxes where appropriate)	
	or	0	For use in weaning patients from inhaled nitric oxide	
	or	\bigcirc	For perioperative use in cardiac surgery patients	
	or (Ο	For use in intensive care as an alternative to nitric oxide	
		0	For use in the treatment of erectile dysfunction secondary to s	pinal 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 intensive care units when the enteral route is not accessible	or children being treated in paediatric intensive care units and neonatal
			O For perioperative use following cardiac surgery	
		or	O For use in persistent pulmonary hypertension of the new	born (PPHN)
			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.

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:

Epoprostenol

Re-a	isses	smen	H dual therapy equired after 6 months ck boxes where appropriate)
and			bed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of ratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ I.
		0	atient has pulmonary arterial hypertension (PAH)
	anc	Ο	AH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications
	anc	Ο	AH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class 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
			A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵) and
			O 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	 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
	anc	L	
		an	D Epoprostenol is to be used as part of PAH dual therapy with either sildenafil or an endothelin receptor antagonist
		an	O Patient is presenting in NYHA/WHO functional class IV
			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

PRESCRIBER	PATIENT:			
Name:	. Name:			
Ward:NHI:				
Epoprostenol - continued				
INITIATION – PAH triple therapy Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a respiratory specialist, cardio a respiratory specialist, cardiologist or rheumatologist, or in accord Hospital. and O Patient has pulmonary arterial hypertension (PAH) and O PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical and O PAH is in New York Heart Association/World Health Organiz and O PAH has been confirmed by right heart catheter and O A mean pulmonary artery pressure (PAPm) great and O A pulmonary capillary wedge pressure (PCWP) and O PAH has been demonstrated to be non-recover defined in the 2022 ECS/ERS Guidelines	eation (NYHA/WHO) functional class III or IV isation ater than 20 mmHg (unless peri Fontan repair) less than or equal to 15 mmHg Wood Units or greater than 160 International Units (dyn s cm ⁻⁵) sponsive in vasoreactivity assessment using iloprost or nitric oxide, as for PAH (see note below for link to these guidelines) † e response to calcium antagonist treatment, according to a validated			
or Patient is a child with PAH secondary to congenital head disorders including severe chronic neonatal lung disea or Patient has palliated single ventricle congenital heart of Fontan circulation requiring the minimising of pulmonal and Epoprostenol is to be used as PAH triple therapy and Patient is on the lung transplant list or Patient is presenting in NYHA/WHO functional of or Patient has tried PAH dual therapy for at I treatment according to a validated risk struents	eart disease or PAH due to idiopathic, congenital or developmental lung ase disease and elevated pulmonary pressures or a major complication of the ary/venous filling pressures			
Patient does not have major life-threatenin scenario	ng comorbidities and triple therapy is not being used in a palliative			

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:			
Epoprostenol - continued				
CONTINUATION Re-assessment required after 2 years Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Patient is continuing to derive benefit from epoprostenol treatment according to a validated PAH risk stratification tool				
Note: † The European Respiratory Journal Guidelines can be found here: diagnosis and treatment of pulmonary hypertension PAH ** the requirement to use a validated risk stratification tool to determine ins Determining insufficient response in children does not require use of a validat currently no such validated tools exist for PAH risk stratification in children.	ufficient response applies to adults.			

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:
Vard:		NHI:
oprost		
INITIATION – I Re-assessmen Prerequisites O Preso	Spiratory specialist, cardiologist or rheumatologist, or in accordation accordation. Patient has pulmonary arterial hypertension (PAH) PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical clip PAH is in New York Heart Association/World Health Organization. Q PAH has been confirmed by right heart catheterist and Q A mean pulmonary artery pressure (PAPm) greater and Q A pulmonary capillary wedge pressure (PCWP) leand Q A pulmonary vascular resistance greater than 2 W and Q PAH has been demonstrated to be non-responder in the 2022 ECS/ERS Guidelines for Q Patient has not experienced an acceptable risk stratification tool** Q Patient is a child with PAH secondary to congenital heart disorders including severe chronic neonatal lung diseas	tion (NYHA/WHO) functional class II, III or IV ation er than 20 mmHg (unless peri Fontan repair) ess than or equal to 15 mmHg Vood Units or greater than 160 International Units (dyn s cm ⁻⁵) ponsive in vasoreactivity assessment using iloprost or nitric oxide, as or PAH (see note below for link to these guidelines) † response to calcium antagonist treatment, according to a validated table or drug-associated type rt disease or PAH due to idiopathic, congenital or developmental lung se
an	O Iloprost is to be used as PAH monotherapy	
	O Patient has experienced intolerable side effects or both bosentan and ambrisentan)	n sildenafil and both the funded endothelin receptor antagonists (i.e.

Patient has an absolute contraindication to sildenafil and an absolute or relative contraindication to endothelin receptor antagonists

()

Signed: Date:

PRESC	RESCRIBER			PATIENT:
Name:	ame:			
Ward: .				NHI:
lopros	st-c	contir	nued	
Re-ass Prereq	essm juisite Pre a re	ent r es (tio escrite espir spita	equir ck bo bed b atory I.	al therapy ed after 6 months xes where appropriate) 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 t has pulmonary arterial hypertension (PAH)
а	und			in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications
a	ind _) Р	AH is	in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
		l l l pr (C	 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 A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm⁵) 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
a		(and	or	Ioprost is to be used as PAH dual therapy with either sildenafil or an endothelin receptor antagonist 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
	Ê	and	or	 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** 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

PRESCRIBER	ESCRIBER PATIENT:		
Name:			
Ward:	NHI:		
loprost - contin	nued		
INITIATION – PAI Re-assessment re Prerequisites (tic O Prescrib a respira Hospital and O Pa and O Pa	H triple therapy equired after 6 months ck boxes where appropriate) bed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of atory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ		
and and	 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 Iloprost is to be used as PAH triple therapy Patient is on the lung transplant list Patient is presenting in NYHA/WHO functional class IV 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 		

 \bigcirc

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.

PRESCR	BER	PATIENT:		
Name:		Name:		
Ward:		NHI:		
lloprost	c - continued			
	UATION ssment required after 2 years isites (tick box where appropriate)			
O Prescribed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				

Patient is continuing to derive benefit from iloprost treatment according to a validated PAH risk stratification tool

Note: † The European Respiratory Journal Guidelines can be found here:	2022 ECS	S/ERS Gui	delines for t	he
diagnosis and treatment of pulmonary hypertension PAH				
** the requirement to use a validated risk stratification tool to determine inst	ufficient re	sponse ap	plies to adul	lts.
Determining insufficient response in children does not require use of a validat	ed PAH ris	k stratificat	ion tool, whe	ere

currently no such validated tools exist for PAH risk stratification in children.

Dermatologicals

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:			
Mafenide acetate				
INITIATION Prerequisites (tick box where appropriate)				
O For the treatment of burns patients				

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	3	PATIENT:
Name:		Name:
Ward:		NHI:
Betametha	sone valerate with clioquinol	
INITIATION Prerequisite	s (tick boxes where appropriate)	
	For the treatment of intertrigo	
	For continuation use	

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:
Pimecrolimus	

Prerequisites (tick boxes where appropriate) ()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 \bigcirc Patient has atopic dermatitis on the eyelid and Patient has at least one of the following contraindications to topical corticosteroids: periorificial dermatitis, rosacea, documented epidermal atrophy, documented allergy to topical corticosteroids, cataracts, glaucoma, or raised intraocular pressure ()

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:

Tacrolimus Ointment

INITIATION

and

Prerequisites (tick boxes where appropriate)

()Prescribed by, or recommended by a dermatologist or paediatrician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

 \bigcirc Patient has atopic dermatitis on the face and

Patient has at least one of the following contraindications to topical corticosteroids: periorificial dermatitis, rosacea, documented epidermal atrophy or documented allergy to topical 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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Methyl aminolevulinate hydrochloride	

INITIATION

Prerequisites (tick box where appropriate)

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

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:	
Terbutaline		

Prerequisites (tick box where appropriate)

()Prescribed by, or recommended by an obstetrician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

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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:
Fina	steri	de			
	ATIOI equis		(tick b	oxes where appropriate)	
	(and	О	Patie	nt has symptomatic benign prostatic hyperplasia	
			Ο	The patient is intolerant of non-selective alpha blockers of	or these are contraindicated
		or	0	Symptoms are not adequately controlled with non-select	ive alpha blockers

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:
Tamsulosin	
INITIATION Prerequisites (tick boxes where appropriate)	
O Patient has symptomatic benign prostatic hyperplasia	
O The patient is intolerant of non-selective alpha blockers or the	ese are contraindicated

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	:		Name:
Ward:			NHI:
Potas	ssium o	citrate	
	ATION equisites	(tick boxes where appropriate)	
	and	The patient has recurrent calcium oxalate urolithiasis	
	0	The patient has had more than two renal calculi in the two yea	rs prior to the application

Hormone Preparations

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:
Oxandrolone - Tab 2.5 mg	
INITIATION Prerequisites (tick box where appropriate)	
O For the treatment of burns patients	

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	e:		Name:
Ward	:		NHI:
Cina	calo	cet	
Re-a	isses equi:	sment requ sites (tick t Prescribed	hyroid carcinoma or calciphylaxis hired after 6 months boxes where appropriate) by, or recommended by a nephrologist or endocrinologist, or in accordance with a protocol or guideline that has been endorsed by NZ Hospital.
	or	and and and	The patient has been diagnosed with a parathyroid carcinoma (see Note) 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 is symptomatic The patient has been diagnosed with calciphylaxis (calcific uraemic arteriolopathy)
		and and	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
		-	parathyroid carcinoma or calciphylaxis poxes where appropriate)
(and	С С	Prescribed the Health	by, or recommended by a nephrologist or endocrinologist, or in accordance with a protocol or guideline that has been endorsed by NZ Hospital.
	and		patient's serum calcium level has fallen to < 3mmol/L patient has experienced clinically significant symptom improvement
Note	: Thi	s does not	include parathyroid adenomas unless these have become malignant.
		-	ry hyperparathyroidism poxes where appropriate)
	and		ent has primary hyperparathyroidism Patient has hypercalcaemia of more than 3 mmol/L with or without symptoms Patient has hypercalcaemia of more than 2.85 mmol/L with symptoms
	and and	O Surg	ery is not feasible or has failed ent has other comorbidities, severe bone pain, or calciphylaxis

and

or

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:
Cinacalcet - continued		
INITIATION – secondary or tertiary I Re-assessment required after 6 month		
Prerequisites (tick boxes where appro		
or	ary hyperparathyroidism and markedly e ptomatic secondary hyperparathyroidisn	levated parathyroid hormone (PTH) with hypercalcaemia

	0	Residual parathyroid tissue has not been localised despite repeat unsuccessful parathyroid explorations
	or O	Parathyroid tissue is surgically inaccessible
	or O	Parathyroid surgery is not feasible
		secondary or tertiary hyperparathyroidism
		uired after 12 months
eauisit	tes (tick l	boxes where appropriate)

hormone (PTH) level to support ongoing cessation of treatment has not been reached

The patient has not received a kidney transplant and trial of withdrawal of cinacalcet is clinically inappropriate

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

RS1826 - Somatropin	
Prader-Willi syndrome - INITIATION	127
Prader-Willi syndrome - CONTINUATION Turner syndrome - INITIATION	124
Turner syndrome - CONTINUATION	128
Adults and adolescents - CONTINUATION Growth hormone deficiency in children - INITIATION	
Growth hormone deficiency in children - CONTINUATION	124 126
Short stature due to chronic renal insufficiency - CONTINUATION	126
Short stature without growth hormone deficiency - CONTINUATION	

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:		Name:
Ward:		NHI:
Som	itropin	
INITI Re-as	 ATION – growth hormone deficiency in children sessment required after 12 months quisites (tick boxes where appropriate) Prescribed by, or recommended by an endocrinologist or paediatric endorsed by the Health NZ Hospital. Growth hormone deficiency causing symptomatic hypoglycae cardiomyopathy, hepatic dysfunction) and diagnosed with GHlife, or from samples during established hypoglycaemia (whole standards of Tanner and Davies (1985) A current bone age is < 14 years (female patients) or < and Peak growth hormone value of < 5.0 mcg per litre in re who are 5 years or older, GH testing with sex steroid pr and If the patient has been treated for a malignancy, they slow of the patient has been treated for a malignancy, they slow of the patient has been treated for a malignancy, they slow of the patient has been treated for a malignancy. 	for bone age/pubertal status if appropriate over 6 or 12 months using the 16 years (male patients) sponse to two different growth hormone stimulation tests. In children
	Appropriate imaging of the pituitary gland has been obt	tained
CONTINUATION – growth hormone deficiency in children Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
and	and Height velocity is greater than or equal to 2.0 cm per year, as and	age (adjusted for bone age/pubertal status if appropriate) while on growth standards of Tanner and Davis (1985) calculated over 6 months rs is likely to be attributable to growth hormone treatment has occurred
Re-as	 ATION – Turner syndrome sessment required after 12 months quisites (tick boxes where appropriate) Prescribed by, or recommended by an endocrinologist or paediatric endorsed by the Health NZ Hospital. 	endocrinologist, or in accordance with a protocol or guideline that has been
	O The patient has a post-natal genotype confirming Turner Syn and	drome

 \odot Height velocity is < 25th percentile over 6-12 months using the standards of Tanner and Davies (1985)

O A current bone age is < 14 years

I confirm that the above details are correct:

and

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:	۰۸	Jame:
Ward:	۰۸	JHI:
Somatropi	in - continued	
	TION – Turner syndrome nent required after 12 months	
Prerequisite	es (tick boxes where appropriate)	
enc	escribed by, or recommended by an endocrinologist or paediatric en dorsed by the Health NZ Hospital.	docrinologist, or in accordance with a protocol or guideline that has been
and	Height velocity greater than or equal to 50th percentile for age (v Ranke's Turner Syndrome growth velocity charts)	while on growth hormone calculated over 6 to 12 months using the
and and	${\sf D}$ Height velocity is greater than or equal to 2 cm per year, calculat	ted over six months
and	A current bone age is 14 years or under	
and) No serious adverse effect that the specialist considers is likely to	be attributable to growth hormone treatment has occurred
	D No malignancy has developed since starting growth hormone	
	 short stature without growth hormone deficiency 	
Re-assessm	nent required after 12 months	
Prerequisite	es (tick boxes where appropriate)	
Pre enc	escribed by, or recommended by an endocrinologist or paediatric en dorsed by the Health NZ Hospital.	docrinologist, or in accordance with a protocol or guideline that has been
and	The patient's height is more than 3 standard deviations below th or delay	e mean for age or for bone age if there is marked growth acceleration
and	Height velocity is < 25th percentile for age (adjusted for bone ag using the standards of Tanner and Davies(1985)	e/pubertal status if appropriate), as calculated over 6 to 12 months
and	A current bone age is < 14 years (female patients) or < 16 years	s (male patients)
C	The patient does not have severe chronic disease (including ma medications known to impair height velocity	lignancy or recognized severe skeletal dysplasia) and is not receiving
	TION – short stature without growth hormone deficiency	
Re-assessm	nent required after 12 months es (tick boxes where appropriate)	
	es (lick boxes where appropriate)	
	escribed by, or recommended by an endocrinologist or paediatric en dorsed by the Health NZ Hospital.	docrinologist, or in accordance with a protocol or guideline that has been
and	Height velocity is greater than or equal to 50th percentile (adjust 12 months using the standards of Tanner and Davies (1985)	ed for bone age/pubertal status if appropriate) as calculated over 6 to
and	$\mathcal D$ Height velocity is greater than or equal to 2 cm per year as calcu	Ilated over six months
and	Current bone age is 14 years or under (female patients) or 16 y	ears 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
<u> </u>)

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	:	Name:		
Ward:		NHI:		
Som	atropin	- continued		
		short stature due to chronic renal insufficiency		
		t required after 12 months (tick boxes where appropriate)		
and		cribed by, or recommended by an endocrinologist, paediatric endocrinologist or renal physician on the recommendation of a endocrinologist rediatric endocrinologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
anu	and O The patient's height is more than 2 standard deviations below the mean and			
	0	Height velocity is < 25th percentile (adjusted for bone age/pubertal status if appropriate) as calculated over 6 to 12 months using the standards of Tanner and Davies (1985)		
	and O and	A current bone age is to 14 years or under (female patients) or to 16 years or under (male patients)		
	and	The patient is metabolically stable, has no evidence of metabolic bone disease and absence of any other severe chronic disease		
	and	The patient is under the supervision of a specialist with expertise in renal medicine		
	O The patient has a GFR less than or equal to 30 ml/min/1.73 m ² as measured by the Schwartz method (Height(cm)/plasma creatinine (umol/l × 40 = corrected GFR (ml/min/1.73 m ²) in a child who may or may not be receiving dialysis			
		O The patient has received a renal transplant and has received < 5mg/m ² /day of prednisone or equivalent for at least 6 months		
		DN – short stature due to chronic renal insufficiency It required after 12 months		
		(tick boxes where appropriate)		
O Prescribed by, or recommended by an endocrinologist, paediatric endocrinologist or renal physician on the recommendation of a endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
and	0	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)		
	and O	Height velocity is greater than or equal to 2 cm per year as calculated over six months		
	and	A current bone age is 14 years or under (female patients) or 16 years or under (male patients)		
	and O and	No serious adverse effect that the patients specialist considers is likely to be attributable to growth hormone has occurred		
	No malignancy has developed after growth hormone therapy was commenced and			
	and	The patient has not experienced significant biochemical or metabolic deterioration confirmed by diagnostic results		
	and	The patient has not received renal transplantation since starting growth hormone treatment		
	\bigcirc	If the patient requires transplantation, growth hormone prescription should cease before transplantation and a new application should be made after transplantation based on the above 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:	
Soma	atropin	- continued	
INITIA Re-as	ATION – ssessmer equisites	Prader-Willi syndrome It 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 rsed 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)	
		O 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	
CONTINUATION – Prader-Willi syndrome Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been			
and	and and and 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 A current bone age is 14 years or under (female patients) or 16 years or under (male patients) 	
a	and and	No serious adverse effect that the patient's specialist con siders is likely to be attributable to growth hormone treatment has occurred No 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	

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:		
Somatropin - continued			
INITIATION – adults and adolescents Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)			
O Prescribed by, or recommended by an endocrinologist or paediatric endorsed by the Health NZ Hospital.	endocrinologist, or in accordance with a protocol or guideline that has been		
treatment of a pituitary tumour)	wth hormone deficiency (e.g. surgical removal of the pituitary for		
and O The patient has undergone appropriate treatment of other hormonal deficiencies and psychological illnesses			
O The patient has severe growth hormone deficiency (see notes	O The patient has severe growth hormone deficiency (see notes)		
and O The patient's serum IGF-I is more than 1 standard deviation below the mean for age and sex and			
	or more using the disease-specific quality of life questionnaire for adult		
Note: For the purposes of adults and adolescents, severe growth hormone de equal to 3 mcg per litre during an adequately performed insulin tolerance test Patients with one or more additional anterior pituitary hormone deficiencies ar isolated growth hormone deficiency require two growth hormone stimulation te an additional test is required, an arginine provocation test can be used with a	(ITT) or glucagon stimulation test. d a known structural pituitary lesion only require one test. Patients with ests, of which, one should be ITT unless otherwise contraindicated. Where		

The dose of somatropin should be started at 0.2 mg daily and be titrated by 0.1 mg monthly until it is within 1 standard deviation of the mean normal value for age and sex; and

The dose of somatropin not to exceed 0.7 mg per day for male patients, or 1 mg per day for female patients. At the commencement of treatment for hypopituitarism, patients must be monitored for any required adjustment in replacement doses of corticosteroid and levothyroxine.

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:	
Somat	tropin	l - con	tinued	
Re-ass	CONTINUATION – adults and adolescents Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been			
and _	endo	orsed b	by the Health NZ Hospital.	
	ar	O nd	The patient has been treated with somatropin for < 12 months	
	ar	O	There has been an improvement in the Quality of Life Assessment defined as a reduction of at least 8 points on the Quality of Life Assessment of Growth Hormone Deficiency in Adults (QoL-AGHDA®) score from baseline	
	ar		Serum IGF-I levels have increased to within ±1SD of the mean of the normal range for age and sex	
		Ο	The dose of somatropin does not exceed 0.7 mg per day for male patients, or 1 mg per day for female patients	
c	or	~		
	O The patient has been treated with somatropin for more than 12 months			
score on treatment (other than due to obvious external factors such as external stressors)			The patient has not had a deterioration in Quality of Life defined as a 6 point or greater increase from their lowest QoL-AGHDA® score on treatment (other than due to obvious external factors such as external stressors)	
			Serum IGF-I levels have continued to be maintained within ±1SD of the mean of the normal range for age and sex (other than for obvious external factors)	
	ar		The dose of somatropin has not exceeded 0.7 mg per day for male patients or 1 mg per day for female patients	
c	or			
O The patient has had a Special Authority approval for somatropin for childhood deficiency in children and no longer m renewal criteria under this indication		The patient has had a Special Authority approval for somatropin for childhood deficiency in children and no longer meets the renewal criteria under this indication		
			The patient has undergone appropriate treatment of other hormonal deficiencies and psychological illnesses	
	O The patient has severe growth hormone deficiency (see notes) and		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 and		The patient's serum IGF-I is more than 1 standard deviation below the mean for age and sex	
		Õ	The patient has poor quality of life, as defined by a score of 16 or more using the disease-specific quality of life questionnaire for adult growth hormone deficiency (QoL-AGHDA®)	
Note: For the purposes of adults and adolescents, severe growth hormone deficiency is defined as a peak serum growth hormone level of less than or equal to 3 mcg per litre during an adequately performed insulin tolerance test (ITT) or glucagon stimulation test. Patients with one or more additional anterior pituitary hormone deficiencies and a known structural pituitary lesion only require one test. Patients with				

isolated growth hormone deficiency require two growth hormone stimulation tests, of which, one should be ITT unless otherwise contraindicated. Where an additional test is required, an arginine provocation test can be used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre. The dose of somatropin 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 deviation of the mean normal value for age and sex; and

The dose of somatropin not to exceed 0.7 mg per day for male patients, or 1 mg per day for female patients.

At the commencement of treatment for hypopituitarism, patients must be monitored for any required adjustment in replacement doses of corticosteroid and levothyroxine.

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			

Prerequisites (tick box where appropriate)

m O~ For a maximum of 14 days' treatment in patients with thyroid cancer who are due to receive radioiodine 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.

PRES	SCRIBER	PATIENT:
Name	5:	Name:
Ward		NHI:
Prop	ylthiouracil	
	ATION equisites (tick boxes where appropriate)	
	O The patient has hyperthyroidism	
	O The patient is intolerant of carbimazole or carbimazole is cont	raindicated
		raindicated

Infections

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:
Streptomycin sulphate	

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. ()

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:	
Amikacin		

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.

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:
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.

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:
Tobramycin Solution for inhalation 60 mg per ml, 5 ml	
INITIATION Prerequisites (tick box where appropriate)	
O Patient has cystic fibrosis	

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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:
Tobramcyin	
INITIATION Prerequisites (tick box where appropriate)	
O For addition to orthopaedic bone cement	

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:
Paromomycin	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:	
Imipenem with cilastatin		

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:
Ertapenem	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:
Meropenem	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:
Ceftazadime	

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. ()

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:
Cefepime	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:
Ceftaroline	
INITIATION – multi-resistant organisn salvage therapy Prerequisites (tick boxes 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. and	
For patients where alternative therapies have failed Or For patients who have a contraindication or hypersensitivity to standard current therapies	

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

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:
Clarithromycin	
INITIATION – Tab 250 mg and oral liquid Prerequisites (tick boxes where appropriate) O Atypical mycobacterial infection or O or Helicobacter pylori eradication or Prophylaxis of infective endocarditis associated with surgical complexity	
INITIATION – Tab 500 mg Prerequisites (tick box where appropriate) O Helicobacter pylori eradication INITIATION – Infusion Prerequisites (tick boxes where appropriate)	
Prerequisites (tick boxes where appropriate)	

Mycobacterium tuberculosis infection where there is drug resistance or intolerance to standard pharmaceutical agents

I confirm that the above details are correct:

Atypical mycobacterial infection

Community-acquired pneumonia

or

or O

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:	
ıme: Name:		
Ward:	NHI:	
Azithromycin		
INITIATION – bronchiolitis obliterans syndrome, cystic fibrosis and atype Prerequisites (tick boxes where appropriate)	ical Mycobacterium infections	
or O Patient has received a lung transplant and requires prophylax	bone marrow transplant and requires treatment for bronchiolitis tis 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)		
O Prescribed by, or recommended by a respiratory specialist or paediatrician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
 For prophylaxis of exacerbations of non-cystic fibrosis bronch and Patient is aged 18 and under and 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.	24 months of azithromycin treatment for non-cystic fibrosis will be subsidised	
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 paediatrician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O The patient has completed 12 months of azithromycin treatment for non-cystic fibrosis bronchiectasis and O Following initial 12 months of treatment, the patient has not received any further azithromycin treatment for non-cystic fibrosis bronchiectasis for a further 12 months, unless considered clinically inappropriate to stop treatment O The patient will not receive more than a total of 24 months' azithromycin cumulative treatment (see note) Note: Indications marked with * are unapproved indications. A maximum of 24 months of azithromycin treatment for non-cystic fibrosis will be subsidised in the community.		
INITIATION – other indications Re-assessment required after 5 days Prerequisites (tick box where appropriate)		

O For any other condition

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

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:	
Ticarcillin with clavulanic acid		

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. ()

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:	
Piperacillin with tazobactam		

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. ()

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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:
Ciprofloxacin	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:

Moxifloxacin

			lycobacterium infection tick boxes where appropriate)
and			ribed 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 or O 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 or O Impaired visual acuity (considered to preclude ethambutol use) or O Significant pre-existing liver disease or hepatotoxicity from tuberculosis medications
			or O Significant documented intolerance and/or side effects following a reasonable trial of first-line medications
	or or		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
	requis	sites (1 Prescr	neumonia tick boxes where appropriate) ribed by, or recommended by an infectious disease specialist or clinical microbiologist, or in accordance with a protocol or guideline that seen endorsed by the Health NZ Hospital.
	or		Immunocompromised patient with pneumonia that is unresponsive to first-line treatment Pneumococcal pneumonia or other invasive pneumococcal disease highly resistant to other antibiotics
INITIATION – Penetrating eye injury Prerequisites (tick box where appropriate)			
and		Prescr Hospit	ribed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ral.
	0	Five da	ays treatment for patients requiring prophylaxis following a penetrating eye injury
			lycoplasma genitalium tick boxes where appropriate)
	and	dor	Has nucleic acid amplification test (NAAT) confirmed Mycoplasma genitalium and is symptomatic O Has tried and failed to clear infection using azithromycin O Has laboratory confirmed azithromycin resistance Treatment is only for 7 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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Tigecycline	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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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:
Daptomycin	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:
Lincomycin	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:
Linezolid	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:
Sulphadiazine	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:
Teicoplanin	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:
Fosfomycin	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:
Pivmecillinam	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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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:
Vancomycin	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:
Aztreonam, Chloramphenicol	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:
Clindamycin	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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 infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Colistin sulphomethate [Colestimethate]	

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. ()

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:
Ketoconazole - Tab 200 mg	

INITIATION

Prerequisites (tick box where appropriate)

()Prescribed by, or recommended by an oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

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:

Amphotericin B - Inj (liposomal) 50 mg vial

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. and Proven or probable invasive fungal infection, to be prescribed under an established protocol or ()Possible invasive fungal infection and () A multidisciplinary team (including an infectious disease physician or a clinical microbiologist) considers the treatment to be appropriate

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:
Amphotericin B - Inj 50 mg vial	

INITIATION

Prerequisites (tick box 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. ()

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:		
Fluconazole			

INITIATION

Prerequisites (tick box where appropriate)

()Prescribed by, or recommended by a consultant, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

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:
Itraconazole	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical immunologist, clinical microbiologist, dermatologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

Use this checklist to determine if a patient meets the restrictions for funding in th	e 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:	
Voriconazole	
INITIATION – Proven or probable aspergillus infection Prerequisites (tick boxes where appropriate)	
Prerequisites (lick boxes where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, haematologist or infectious disease specialist, guideline that has been endorsed by the Health NZ Hospital.	or in accordance with a protocol or
O Patient is immunocompromised	
O 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, haematologist or infectious disease specialist, guideline that has been endorsed by the Health NZ Hospital.	or in accordance with a protocol or
O Patient is immunocompromised	
O Patient has possible invasive aspergillus infection and	
A multidisciplinary team (including an infectious disease physician) considers the treatment to be ap	propriate
INITIATION – Resistant candidiasis infections and other moulds Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, haematologist or infectious disease specialist, guideline that has been endorsed by the Health NZ Hospital.	or in accordance with a protocol or
O Patient is immunocompromised	
O Patient has fluconazole resistant candidiasis	
O Patient has mould strain such as Fusarium spp. and Scedosporium spp	
A multidisciplinary team (including an infectious disease physician or clinical microbiologist) conside	rs the treatment to be appropriate
INITIATION – Invasive fungal infection prophylaxis Re-assessment required after 6 months	
Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline NZ Hospital.	that has been endorsed by the Health
O The patient is at risk of invasive fungal infection	

O Voriconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease specialist, paediatric haematologist or paediatric oncologist

O Prescribing voriconazole is in accordance with a protocol or guideline that has been endorsed by the Health New Zealand - Te Whatu Ora Hospital in the specific settings where there is a greater than 10% risk of invasive fungal infection (IFI)

and

or

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	ER			PATIENT:
Name	ə:				Name:
Ward	:				NHI:
Vori	cona	zole) - co	ontinued	
Re-a	issess equis O F	i tes (Presc	tick b		cordance with a protocol or guideline that has been endorsed by the Health
	(and	Ο	The p	patient is at risk of invasive fungal infection	
		or	0	Voriconazole is prescribed by, or recommended by a had paediatric haematologist or paediatric oncologist	ematologist, transplant physician, infectious disease specialist,
			0		ol or guideline that has been endorsed by the Health New Zealand - Te is a greater than 10% risk of invasive fungal infection (IFI)
	(

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

			nt required after 6 weeks
			(tick boxes where appropriate)
(and			cribed by, or recommended by a haematologist or infectious disease specialist, or in accordance with a protocol or guideline that has been brsed by the Health NZ Hospital.
		or	 Patient has acute myeloid leukaemia Patient is planned to receive a stem cell transplant and is at high risk for aspergillus infection
	anc	0	Patient is to be treated with high dose remission induction therapy or re-induction therapy
Re-a	sses		DN ht required after 6 weeks (tick boxes where appropriate)
(and			cribed by, or recommended by a haematologist or infectious disease specialist, or in accordance with a protocol or guideline that has been brsed by the Health NZ Hospital.
	anc	0	Patient has previously received posaconazole prophylaxis during remission induction therapy
			O Patient is to be treated with high dose remission re-induction therapy
		or	O Patient is to be treated with high dose consolidation therapy
			O Patient is receiving a high risk stem cell transplant
\subseteq			
			Invasive fungal infection prophylaxis nt required after 6 months
Prer	equi	sites	(tick boxes where appropriate)
(and			cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health lospital.
	anc	0	The patient is at risk of invasive fungal infection
			O Posaconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease specialist, paediatric haematologist or paediatric oncologist
		or	O Prescribing posaconazole is in accordance with a protocol or guideline that has been endorsed by the Health New Zealand - Te Whatu Ora Hospital in the specific settings where there is a greater than 10% risk of invasive fungal infection (IFI)

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	ER			PATIENT:
Name	e:				Name:
Ward	:				NHI:
Posa	acon	azo	le - a	continued	
Re-a	ssess equis	ites Presc	t requ (tick b		cordance with a protocol or guideline that has been endorsed by the Health
	(and	О	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,
	or		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)
			\cup		

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:		
Flucytosine			

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:
Caspofungin	

Prer	equi	sites (tick boxes where appropriate)	
and	С	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.	
	or	O Proven or probable invasive fungal infection, to be prescribed under an established protocol	
		O Possible invasive fungal infection	
		A multidisciplinary team (including an infectious disease physician or a clinical microbiologist) considers the treatment to be appropriate	

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:
Clofazimine	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:
Dapsone	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:
Cycloserine	

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. ()

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:
Isoniazid with rifampicin	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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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:
Pyrazinamide	

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. ()

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:
Rifampicin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, dermatologist, internal medicine physician, paediatrician or public health physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Bedaquiline		
Re-assessmen	nulti-drug resistant tuberculosis t required after 6 months	
Prerequisites	(tick boxes where appropriate)	
and	The person has multi-drug resistant tuberculosis (MDR-TB)	
0	Ministry of Health's Tuberculosis Clinical Network has reviewed treatment regimen	ed the individual case and recommends bedaquiline as part of the

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:
Isoniazid	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:
Rifabutin	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:
Ethambutol hydrochloride	

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.

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:
Para-aminosalicylic Acid	

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. ()

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:
Protionamide	

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. ()

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:
Albendazole	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:
Ivermectin	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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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:
Artemether with lumefantrine	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:
Artesunate	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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)

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. ()

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:
Chloroquine phosphate	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:
Mefloquine hydrochloride	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:
Pentamidine isethionate	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:
Primaguine phosphate	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:
Pyrimethamine	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:
Quinine dihvdrochloride	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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:
Sodium stibogluconate	

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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)

Prescribed by, or recommended by a maternal-foetal medicine specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	
Nitazoxanide		

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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	3	PATIENT:
Name:		Name:
Ward:		NHI:
Non-Nucle	oside Reverse Transcriptase Inhibitors	
-	- Confirmed HIV s (tick box where appropriate)	
O Pat	ient has confirmed HIV infection	
	- Prevention of maternal transmission s (tick boxes where appropriate)	
or C	Prevention of maternal foetal transmissionTreatment of the newborn for up to eight weeks	
	 Post-exposure prophylaxis following exposure to HIV is (tick boxes where appropriate) Treatment course to be initiated within 72 hours post exposited 	Jre
	unknown or detectable viral load greater than 200 cop	tive vaginal intercourse with a known HIV positive person with an ies per ml
	or O Patient has shared intravenous injecting equipment with a known HIV positive person or O Patient has had non-consensual intercourse and the clinician considers that the risk assessment indicates prophylaxis is required	
		erson from a high HIV prevalence country or risk group whose HIV status
Note: Refer	to local health pathways or the Australasian Society for HIV, Vir	al Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.ashn
Prerequisite	- Percutaneous exposure s (tick box where appropriate) ient has percutaneous exposure to blood known to be HIV posi	tive

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:			Name:
Ward:			NHI:
Nucleosid	le Re	verse Transcriptase Inhibitors	
INITIATION Prerequisit		firmed HIV < box where appropriate)	
Pa	atient h	as confirmed HIV infection	
		vention of maternal transmission (boxes where appropriate)	
or (`	evention of maternal foetal transmission eatment of the newborn for up to eight weeks	
Prerequisit	es (ticł	t-exposure prophylaxis following exposure to HIV (boxes where appropriate) eatment course to be initiated within 72 hours post exposu	e
and	or	Patient has had condomless anal intercourse or recepti unknown or detectable viral load greater than 200 copie	ve vaginal intercourse with a known HIV positive person with an is per ml
	O Patient has shared intravenous injecting equipment with a known HIV positive person		
	or or	Patient has had non-consensual intercourse and the cli required	nician considers that the risk assessment indicates prophylaxis is
	C	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 loca	al health pathways or the Australasian Society for HIV, Vira	Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.ashn
Prerequisit	es (ticł	cutaneous exposure (box where appropriate) as percutaneous exposure to blood known to be HIV positi	ve

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:	Name:			Name:
Ward:	Vard:			NHI:
Protea	ase l	nhibit	ors	
			rmed HIV box where appropriate)	
С) Pat	ient ha	s confirmed HIV infection	
			ention of maternal transmission boxes where appropriate)	
C	O Prevention of maternal foetal transmission or O Treatment of the newborn for up to eight weeks			
			exposure prophylaxis following exposure to HIV boxes where appropriate)	
a	and () Trea	tment course to be initiated within 72 hours post exposur	e
		0	Patient has had condomless anal intercourse or reception unknown or detectable viral load greater than 200 copie	ve vaginal intercourse with a known HIV positive person with an s per ml
		or ()	Patient has shared intravenous injecting equipment with	a known HIV positive person
		or O	Patient has had non-consensual intercourse and the clin required	nician considers that the risk assessment indicates prophylaxis is
		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:	Note: Refer to local health pathways or the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.ashr			
	quisite	s (tick	Itaneous exposure box where appropriate) s percutaneous exposure to blood known to be HIV positiv	ve

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:		Name:
Ward:		NHI:
Strand Tra	nsfer Inhibitors	
	 – Confirmed HIV es (tick box where appropriate) 	
О Ра	tient has confirmed HIV infection	
	 Prevention of maternal transmission es (tick boxes where appropriate) 	
or	Prevention of maternal foetal transmissionTreatment of the newborn for up to eight weeks	
	 Post-exposure prophylaxis following exposure to HIV es (tick boxes where appropriate) 	
and	Treatment course to be initiated within 72 hours post expos	ure
	O Patient has had condomless anal intercourse or recept unknown or detectable viral load greater than 200 copt	ptive vaginal intercourse with a known HIV positive person with an bies per ml
	O Patient has shared intravenous injecting equipment w	ith a known HIV positive person
	required	clinician considers that the risk assessment indicates prophylaxis is
	O Patient has had condomless anal intercourse with a p is unknown	erson from a high HIV prevalence country or risk group whose HIV status
Note: Refer	to local health pathways or the Australasian Society for HIV, Vi	ral Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.ash
Prerequisite	 Percutaneous exposure es (tick box where appropriate) tient has percutaneous exposure to blood known to be HIV pos 	itive

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).

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)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist, otolaryngologist or oral surgeon, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	
Foscarnet sodium		

INITIATION

Prerequisites (tick box where appropriate)

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. ()

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)

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. ()

			determine if a patient meets the restrictions for funding in the nunity funding, see the Special Authority Criteria.	hospital setting. For more details, refer to Section H of the Pharmaceutical
PRESC	RIBE	R		PATIENT:
Name:				Name:
Ward:				NHI:
Valgar	ncic	lovir		
Re-ass	sessm juisit	nent rec es (tick	asplant cytomegalovirus prophylaxis quired after 3 months < box where appropriate) as undergone a solid organ transplant and requires valgancio	clovir for CMV prophylaxis
Re-ass	sessm	nent rec	- Transplant cytomegalovirus prophylaxis quired after 3 months < boxes where appropriate)	
C	or	and C and C	CMV prophylaxis Patient is to receive a maximum of 90 days of valganciclo	ejection and requires further valganciclovir therapy for CMV
Re-ass	sessm	nent rec	g transplant cytomegalovirus prophylaxis quired after 12 months < boxes where appropriate)	
and _		escribe ospital.		nce with a protocol or guideline that has been endorsed by the Health NZ
	and	or C	 tient has undergone a lung transplant The donor was cytomegalovirus positive and the patient is The recipient is cytomegalovirus positive tient has a high risk of CMV disease 	s cytomegalovirus negative
		-	omegalovirus in immunocompromised patients (boxes where appropriate)	
a	and) Pat	tient is immunocompromised	
		or or or C	 Patient has cytomegalovirus syndrome or tissue invasive Patient has rapidly rising plasma CMV DNA in absence of Patient has cytomegalovirus retinitis 	

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:
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 or O Treatment of the newborn for up to eight weeks	
INITIATION – Post-exposure prophylaxis following non-occupational exp Prerequisites (tick boxes where appropriate)	posure to HIV
O Treatment course to be initiated within 72 hours post exposure	
 Patient has had unprotected receptive anal intercourse of O Patient has shared intravenous injecting equipment with or O Patient has had non-consensual intercourse and the clin required 	
INITIATION – Percutaneous exposure Prerequisites (tick box where appropriate) O Patient has percutaneous exposure to blood known to be HIV positiv	re
INITIATION – 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 symp and O The Practitioner considers the patient is at elevated risk of HIV	toms of acute HIV infection and has been assessed for HIV seroconversion
	Hepatitis and Sexual Health Medicine clinical guidelines (https://ashm.org.au/HIV/F
CONTINUATION – Pre-exposure prophylaxis Re-assessment required after 24 months Prerequisites (tick boxes where appropriate)	
and	toms of acute HIV infection and has been assessed for HIV seroconversion
O The Practitioner considers the patient is at elevated risk of HIV	
Note: Heter to local health pathways or the Australasian Society for HIV, Viral	Hepatitis and Sexual Health Medicine clinical guidelines (https://ashm.org.au/HIV/F

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:
Oselta	mivir	
INITIAT Prerequ	TON uisites (tick boxes where appropriate)	
	O Only for hospitalised patient with known or suspected influenza	a
or O For prophylaxis of influenza in hospitalised patients as part of a Health NZ Hospital approved infections contro		a Health NZ Hospital approved infections control plan

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:	
Zanamivir - Powder for inhalation 5 mg				
INITIATION Prerequisites (tick boxes where appropriate)				
		O Only for hospitalised patient with known or suspected influenz	a	
O For prophylaxis of influenza in hospitalised patients as part of a Health NZ Hospital approved infections control plan		a Health NZ Hospital approved infections control plan		

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 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 ()

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:	
Remdesivir		

INITIATION – Treatment of mild to moderate COVID-19

Prerequisites (tick box where appropriate)

 \bigcirc 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

INITIATION – COVID-19 in hospitalised patients Re-assessment required after 5 doses Prerequisites (tick boxes where appropriate) () Patient is hospitalised with confirmed (or probable) symptomatic COVID-19 and Patient is considered to be at high risk of progression to severe disease and Patient's symptoms started within the last 7 days and Patient does not require, or is not expected to require, mechanical ventilation and Not to be used in conjunction with other funded COVID-19 antiviral treatments and Treatment not to exceed five 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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Interferon gamma	
INITIATION Prerequisites (tick box where appropriate)	
${\rm O}$ Patient has chronic granulomatous disease and requires interferon g	gamma

RS1827 - Pegylated interferon alfa-2a

Chronic Hepatitis C - genotype 1 infection treatment more than 4 years prior - INITIATION Chronic hepatitis C - genotype 1 infection - CONTINUATION	
Chronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV or genotype 2 or 3 post liver tra - INITIATION	
Chronic hepatitis C - genotype 2 or 3 infection without co-infection with HIV - INITIATION Hepatitis B - INITIATION	
Myeloproliferative disorder or cutaneous T cell lymphoma - INITIATION Myeloproliferative disorder or cutaneous T cell lymphoma - CONTINUATION	
Ocular surface squamous neoplasia - INITIATIÓN Ocular surface squamous neoplasia - CONTINUATION	
Post-allogenic bone marrow transplant - INITIATION Post-allogenic bone marrow transplant - CONTINUATION	221

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

INITIATION – Chronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV or genotype 2 or 3 post liver transplant Re-assessment required after 48 weeks
Prerequisites (tick boxes where appropriate)
O Patient has chronic hepatitis C, genotype 1, 4, 5 or 6 infection
O Patient has chronic hepatitis C and is co-infected with HIV or
O Patient has chronic hepatitis C genotype 2 or 3 and has received a liver transplant
Note: Consider 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 treatment since this is predictive of treatment failure. Consider reducing treatment to 24 weeks if serum HCV RNA level at Week 4 is undetectable by sensitive PCR assay (less than 50IU/ml) AND Baseline serum HCV RNA is less than 400,000IU/ml.
CONTINUATION – Chronic hepatitis C - genotype 1 infection Re-assessment required after 48 weeks Prerequisites (tick boxes where appropriate)
O Prescribed by, or recommended by a gastroenterologist, infectious disease specialist or general physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
O Patient has chronic hepatitis C, genotype 1 and
O Patient has had previous treatment with pegylated interferon and ribavirin and
O Patient has responder relapsed
O Patient was a partial responder
Patient is to be treated in combination with boceprevir
INITIATION – Chronic Hepatitis C - genotype 1 infection treatment more than 4 years prior Re-assessment required after 48 weeks Prerequisites (tick boxes where appropriate)
O Prescribed by, or recommended by a gastroenterologist, infectious disease specialist or general physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
O Patient has chronic hepatitis C, genotype 1 and
Patient has had previous treatment with pegylated interferon and ribavirin
O Patient has responder relapsed
O Patient was a partial responder
O Patient received interferon treatment prior to 2004
And O Patient is to be treated in combination with boceprevir

Use this checklist to determine if a patient meets the restrictions for Schedule. For community funding, see the Special Authority Criterian Schedule.	or funding in the hospital setting . For more details, refer to Section H of the Pharmaceutical eria.
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pegylated interferon alfa-2a - continued	
INITIATION – Chronic hepatitis C - genotype 2 or 3 infection Re-assessment required after 6 months Prerequisites (tick box where appropriate)	without co-infection with HIV
O Patient has chronic hepatitis C, genotype 2 or 3 infecti	ion
INITIATION – Hepatitis B	
Re-assessment required after 48 weeks Prerequisites (tick boxes where appropriate)	
	st, infectious disease specialist or general physician, or in accordance with a protocol or ospital.
Patient has confirmed Hepatitis B infection (HBs	sAg positive for more than 6 months)
O Patient is Hepatitis B treatment-naive and	
O ALT > 2 times Upper Limit of Normal	
And O HBV DNA < 10 log10 IU/ml	
and O HBeAg positive	
or O Serum HBV DNA greater than or equal to moderate fibrosis)	2,000 units/ml and significant fibrosis (greater than or equal to Metavir Stage F2 or
and O Compensated liver disease	
and O No continuing alcohol abuse or intravenous drug	g use
Not co-infected with HCV, HIV or HDV	
and ○ Neither ALT nor AST > 10 times upper limit of no	ormal
and O No history of hypersensitivity or contraindication	as to pegylated interferon
INITIATION – myeloproliferative disorder or cutaneous T cel Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	ll lymphoma
O Patient has a cutaneous T cell lymphoma*	
O Patient has a myeloproliferative disorder*	
O Patient is intolerant of hydroxyurea	
and O Treatment with anagrelide and busulfan is	not clinically appropriate
or	
O Patient has a myeloproliferative disorder and	
O Patient is pregnant, planning pregnancy or	r lactating

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:
Pegylated interferon alfa-2a - continued	
CONTINUATION – myeloproliferative disorder or cutaneous T cell lymph Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	oma
No evidence of disease progression and The treatment remains appropriate and patient is benefitting f and	rom treatment
O Patient has a cutaneous T cell lymphoma*	
O Patient has a myeloproliferative disorder*	
O Remains intolerant of hydroxyurea and trea or O Patient is pregnant, planning pregnancy or	tment with anagrelide and busulfan remains clinically inappropriate
Note: Indications marked with * are unapproved indications	
 O Prescribed by, or recommended by an ophthalmologist, or in accord 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 accord Hospital.	ance with a protocol or guideline that has been endorsed by the Health NZ
O The treatment remains appropriate and patient is benefitting from tr Note: Indications marked with * are unapproved indications	eatment
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 ha	s 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	

Signed: Date:

Musculoskeletal 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:
Edrophonium chloride	
INITIATION Prerequisites (tick box where appropriate)	
${ m O}~$ 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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:

Denosumab

(and	С	The	patient has established osteoporosis
		0	History of one significant osteoporotic fracture demonstrated radiologically, with a documented T-Score less than or equal to -2.5, that incorporates BMD measured using dual-energy x-ray absorptiometry (DEXA)
	or	0	History of one significant osteoporotic fracture, demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of logistical, technical or pathophysiological reasons
	or	0	History of two significant osteoporotic fractures demonstrated radiologically
	or	Ο	Documented T-Score less than or equal to -3.0
	or	0	A 10-year risk of hip fracture greater than or equal to 3%, calculated using a published risk assessment algorithm that incorporates BMD measured using DEXA
and	\geq		
	or	Ο	Bisphosphonates are contraindicated because the patient's creatinine clearance or eGFR is less than 35 mL/min
		Ο	The patient has experienced at least two symptomatic new fractures or a BMD loss greater than 2% per year, after at least 12 months' continuous therapy with a funded antiresorptive agent
	or	0	Bisphosphonates result in intolerable side effects
	or	\bigcirc	Intravenous bisphosphonates cannot be administered due to logistical or technical reasons

INITIATION – Hypercalcaemia

Prerequisites (tick boxes where appropriate)



Patient has hypercalcaemia of malignancy

Patient has severe renal impairment

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:	

Raloxifene

qui	sites	(tick boxes where appropriate)
or	0	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)
	0	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 to many patients under 75 years of age
or	Ο	History of two significant osteoporotic fractures demonstrated radiologically
or	Ο	Documented T-Score greater than or equal to -3.0 (see Notes)
or or	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)
	Ο	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	PATIENT:	
Name:	Name:	
Ward:	NHI:	

Teriparatide

	NITIATION Re-assessment required after 18 months					
Prer	equisites	(tick boxes where appropriate)				
	and	The patient has severe, established osteoporosis				
	and	The patient has a documented T-score less than or equal to -3.0 (see Notes)				
	and	The patient has had two or more fractures due to minimal trauma				
	0	The patient has experienced at least one symptomatic new fracture after at least 12 months' continuous therapy with a funded antiresorptive agent at adequate doses (see Notes)				

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:

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:
Rasburicase	

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.

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:		

Febuxostat

(С	Patie	ent has been diagnosed with gout
and	_		
		0	The patient has a serum urate level greater than 0.36 mmol/l despite treatment with allopurinol at doses of at least 600 mg/day and addition of probenecid at doses of up to 2 g per day or maximum tolerated dose
	or	Ο	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	0	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)
	or	\bigcirc	The patient has previously had an initial Special Authority approval for benzbromarone for treatment of gout.

INITIATION – Tumour lysis syndrome Re-assessment required after 6 weeks

Prerequisites (tick boxes where appropriate)

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.

O Patient is scheduled to receive cancer therapy carrying an intermediate or high risk of tumour lysis syndrome and

O Patient has a documented history of allopurinol intolerance

CONTINUATION – Tumour lysis syndrome

Re-assessment required after 6 weeks **Prerequisites** (tick box where appropriate)

()

and

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.

O The treatment remains appropriate and patient is benefitting from 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:	

Sugammadex

 INITIATION Prerequisites (tick boxes where appropriate)						
or	0	Patient requires reversal of profound neuromuscular blockade following rapid sequence induction that has been undertaken using rocuronium (i.e. suxamethonium is contraindicated or undesirable)				
or	Ο	Severe neuromuscular degenerative disease where the use of neuromuscular blockade is required				
	Ο	Patient has an unexpectedly difficult airway that cannot be intubated and requires a rapid reversal of anaesthesia and neuromuscular blockade				
or or	Ο	The duration of the patient's surgery is unexpectedly short				
	Ο	Neostigmine or a neostigmine/anticholinergic combination is contraindicated (for example the patient has ischaemic heart disease, morbid obesity or COPD)				
or	0	Patient has a partial residual block after conventional reversal				

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)	
${ m O}~$ For in-vivo investigation of allergy only	

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					

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 spectory by the Health NZ Hospital. and O The patient has amyotrophic lateral sclerosis with disease dur and O The patient has at least 60 percent of predicted forced vital car and O The patient has not undergone a tracheostomy and O The patient has not experienced respiratory failure and	
O The patient is ambulatory	

or O The patient is able to use upper limbs

or $\hfill O$ The patient is able to swallow

CONTINUATION

Re-assessment required after 18 months

Prerequisites (tick boxes where appropriate)

				patient has not undergone a tracheostomy
	and (and	С	The p	patient has not experienced respiratory failure
	ana		0	The patient is ambulatory
		or	Ο	The patient is able to use upper limbs
	or	Ο	The patient is able to swallow	

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

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: I			Name:			
Ward:			NHI:			
Meth	oxyflur	ane				
INITIATION Prerequisites (tick boxes where appropriate)						
	and	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 or	r nurse who is trained in the use of methoxyflurane			

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:		
Paracetamol			

INITIATION

Prerequisites (tick box where appropriate)

()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

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)	
m O For post-herpetic neuralgia or diabetic peripheral neuropathy	

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:

Vigabatrin

	IATIO					
				ed after 15 months		
Prer	equis	ites	(tick bc	ixes where appropriate)		
			~			
		or	Ο	Patient has infantile spasms		
			and	O Patient has epilepsy		
				O Seizures are not adequately controlled with optimal treatment with other antiepilepsy agents		
				O Seizures are controlled adequately but the patient has experienced unacceptable side effects from optimal treatment with other antiepilepsy agents		
		or	\square			
			Ο	Patient has tuberous sclerosis complex		
	and					
				Patient is, or will be, receiving regular automated visual field testing (ideally before starting therapy and on a 6-monthly basis thereafter)		
		or	0	It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields		
\square						
CON	ΙΤΙΝυ	ΑΤΙΟ	N			
Prer	equis	ites	(tick bc	exes where appropriate)		
	and	0	The pa	atient has demonstrated a significant and sustained improvement in seizure rate or severity and or quality of life		
		or		Patient is receiving regular automated visual field testing (ideally every 6 months) on an ongoing basis for duration of treatment with vigabatrin		
			Ο	It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields		

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:
Lacosamide	
INITIATION Re-assessment required after 15 months Prerequisites (tick boxes where appropriate)	
Patient has focal epilepsy and	
	erienced unacceptable side effects from, optimal treatment with all of the ny two of carbamazepine, lamotrigine, and phenytoin sodium (see Note)
Note: Those of childbearing potential are not required to trial phenytoin sodiu required to trial sodium valproate.	m, sodium valproate, or topiramate. Those who can father children are not

CONTINUATION

Prerequisites (tick box where appropriate)

() Patient has demonstrated a significant and sustained improvement in seizure rate or severity and/or quality of life compared with that prior to starting lacosamide 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:
Otivin antal	

Stiripentol

and

()

INITIATION Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)
O 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.
O Patient has confirmed diagnosis of Dravet syndrome
and O Seizures have been inadequately controlled by appropriate courses of sodium valproate, clobazam and at least two of the following: topiramate, levetiracetam, ketogenic diet
Note: Those of childbearing potential are not required to trial sodium valproate or topiramate. Those who can father children are not required to trial sodium valproate.
CONTINUATION
Prerequisites (tick box where appropriate)

O 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 continues to benefit from treatment as measured by reduced seizure frequency 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:	
Hyoscine hydrobromide - Patch 1.5 mg		

 equi		(tick boxes where appropriate)
	0	Control of intractable nausea, vomiting, or inability to swallow saliva in the treatment of malignancy or chronic disease where the patient cannot tolerate or does not adequately respond to oral anti-nausea agents
or	0	Control of clozapine-induced hypersalivation where trials of at least two other alternative treatments have proven ineffective
	Ο	For treatment of post-operative nausea and vomiting where cyclizine, droperidol and a 5HT3 antagonist have proven ineffective, are not tolerated or are contraindicated

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:	
Aprepitant		

Prerequisites (tick box where appropriate)

O Patient is undergoing highly emetogenic chemotherapy and/or anthracycline-based chemotherapy for the treatment of malignancy

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:

Paliperidone

Re-a	INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)							
	or	0		patient has had an initial Special Authority approval for risperidone depot injection or olanzapine depot injection or aripiprazole ot injection				
		an	O d	The patient has schizophrenia or other psychotic disorder The patient has been unable to adhere to treatment using oral atypical antipsychotic agents				
		an	dO	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 the last 12 months				

CONTINUATION

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

O The initiation of paliperidone depot injection has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of an atypical antipsychotic depot injection

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:
Paliperidone palmitate	
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O The patient has schizophrenia and O The patient has had an initial Special Authority approval for pa	aliperidone once-monthly depot injection
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate) O The initiation of paliperidone depot injection has been associated wi corresponding period of time prior to the initiation of an atypical antip	

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)

 \bigcirc The initiation of olanzapine depot injection has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of an atypical antipsychotic depot injection

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:		

Risperidone

Re-a		smer		uired after 12 months poxes where appropriate)
	or	0		patient has had an initial Special Authority approval for paliperidone depot injection or olanzapine depot injection or aripiprazole tinjection
		an	O d	The patient has schizophrenia or other psychotic disorder
		an	d O	The patient has not been able to adhere to treatment using oral atypical antipsychotic agents 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 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 fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of an atypical antipsychotic depot injection \bigcirc

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:	

Aripiprazole

	or	O The patient has had an initial Special Authority approval for risperidone depot injection or paliperidone depot injection or olanzapine depot injection
		O The patient has schizophrenia or other psychotic disorder
		The patient has received treatment with oral atypical antipsychotic agents but has been unable to adhere
		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)

- All of the following:
 - The patient has schizophrenia; and
 - The patient has tried but has not been able to adhere with treatment using oral atypical antipsychotic agents; 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 the last 12 months.

and

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:
Diazepam	
Prerequisites (tick box where appropriate)	
O 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

Only for use in children where diazepam tablets are not appropriate

SCRIB	ER		PATIENT:
ə:			Name:
:			NHI:
iple	Scler	osis	
teriflu assess	nomic ment r	le equired	clerosis - dimethyl fumarate, fingolimod, glatiramer acetate, interferon beta-1-alpha, interferon beta-1-beta, natalizun after 12 months s where appropriate)
	Prescril IZ Hos		or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the He
	(and	neu	ignosis of multiple sclerosis (MS) meets the McDonald 2017 diagnostic criteria for MS and has been confirmed by a urologist
	and		ient has an EDSS score between 0 – 6.0
	and	Pat	tient has had at least one significant attack of MS in the previous 12 months or two significant attacks in the past 24 months
		and and	 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) 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
		and C	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)
		c	 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 C Each significant attack is a recurrent paroxysmal symptom of multiple sclerosis (tonic seizures/spasms, trigeminal neuralgia, Lhermitte's symptom)
	and (and	D Evi	dence of new inflammatory activity on an MRI scan within the past 24 months
		or or or	 A sign of that new inflammatory activity on MRI scanning (in criterion 5 immediately above) is a gadolinium enhancing lesion A sign of that new inflammatory activity is a lesion showing diffusion restriction A sign of that new inflammatory is a T2 lesion with associated local swelling
		or 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
		C	A sign of that new inflammatory activity is new T2 lesions compared with a previous MRI scan

Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.

()

and

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:	

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)

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 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.	

CRIBER	PATIENT:
:	Name:
	NHI:
iple Sclerosis	
ssessment required equisites (tick boxes	clerosis - ocrelizumab after 12 months s where appropriate) or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Hea
and Pat	gnosis of multiple sclerosis (MS) meets the McDonald 2017 diagnostic criteria for MS and has been confirmed by a irologist ient has an EDSS score between 0 – 6.0 ient has had at least one significant attack of MS in the previous 12 months or two significant attacks in the past 24 months
and and and and	 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) 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) C Each significant attack is severe enough to change either the EDSS or at least one of the Kurtze Functional
and	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) dence 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
or or or	 A sign of that new inflammatory activity is a lesion showing diffusion restriction A sign of that new inflammatory is a T2 lesion with associated local swelling 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 A sign of that new inflammatory activity is new T2 lesions compared with a previous MRI scan

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.					
PRES	SCRIBER PATIENT:				
Name	e: Name:				
Ward	: NHI:				
Mult	iple Sclerosis - continued				
	TINUATION – Multiple Sclerosis - ocrelizumab requisites (tick box where appropriate)				
and	O 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.				
(Note	 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) Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted. 				
Re-a	IATION – Primary Progressive Multiple Sclerosis assessment required after 12 months requisites (tick boxes where appropriate) O 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.				
	Diagnosis of primary progressive multiple sclerosis (PPMS) meets the 2017 McDonald criteria and has been confirmed by a neurologist and				
	O Patient has an EDSS 2.0 (score equal to or greater than 2 on pyramidal functions) to EDSS 6.5				
	And O Patient has no history of relapsing remitting multiple sclerosis				
	ITINUATION – Primary Progressive Multiple Sclerosis requisites (tick box where appropriate)				
) and	O 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.				
and	O Patient has had an EDSS score of less than or equal to 6.5 at any time in the last six months (ie patient has walked 20 metres with bilateral				

assistance/aids, without rest in the last six 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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Melatonin	
INITIATION – insomnia secondary to neurodevelopmental disorder Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a psychiatrist, paediatrician, neur guideline that has been endorsed by the Health NZ Hospital. and O Patient has been diagnosed with persistent and distressing ins limited to, autism spectrum disorder or attention deficit hyperaction and O Behavioural and environmental approaches have been tried or and O Funded modified-release melatonin is to be given at doses no gand O Patient is aged 18 years or under	omnia secondary to a neurodevelopmental disorder (including, but not ctivity disorder) are inappropriate
CONTINUATION – insomnia secondary to neurodevelopmental disorder Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a psychiatrist, paediatrician, neur guideline that has been endorsed by the Health NZ Hospital. and O Patient is aged 18 years or under and O Patient has demonstrated clinically meaningful benefit from fur and O Patient has had a trial of funded modified-release melatonin dis persistent and distressing insomnia and O Funded modified-release melatonin is to be given at doses no p	nded modified-release melatonin (clinician determined) scontinuation within the past 12 months and has had a recurrence of
INITIATION – insomnia where benzodiazepines and zopiclone are contrai Prerequisites (tick boxes where appropriate) O Patient has insomnia and benzodiazepines and zopiclone are of and O For in-hospital use only	

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:

Nusinersen

Re-asses	IITIATION e-assessment required after 12 months					
Prerequi	sites (tick boxes where appropriate)					
and	O Patient has genetic documentation of homozygous SMN1 gene deletion, homozygous SMN1 point mutation, or compound heterozygous mutation					
and	O Patient is 18 years of age or under					
and	O Patient has experienced the defined signs and symptoms of SMA type I, II or IIIa prior to three years of age or					
	O Patient is pre-symptomatic					
	O Patient has three or less copies of SMN2					
	UATION ssment required after 12 months					
	sites (tick boxes where appropriate)					
and	O There has been demonstrated maintenance of motor milestone function since treatment initiation					
and	O Patient does not require invasive permanent ventilation (at least 16 hours per day), in the absence of a potentially reversible cause while being treated with nusinersen					
and	d O Nusinersen not to be administered in combination other SMA disease modifying treatments or gene 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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:

Risdiplam

Re-a	INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)						
) and	Patient has genetic documentation of homozygous SMN1 gene deletion, homozygous SMN1 point mutation, or compound heterozygous mutation					
		Patient is 18 years of age or under					
	or	O Patient has experienced the defined signs and symptoms of SMA type I, II or IIIa prior to three years of age					
		O Patient is pre-symptomatic					
		O Patient has three or less copies of SMN2					
Re-a		DN It required after 12 months (tick boxes where appropriate)					
	and	There has been demonstrated maintenance of motor milestone function since treatment initiation					
	0	Patient does not require invasive permanent ventilation (at least 16 hours per day), in the absence of a potentially reversible cause while being treated with risdiplam					
	and	Risdiplam not to be administered in combination other SMA disease modifying treatments or gene therapy					

and

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	SCRIB	ER		PATIENT:
Name	:			Name:
Ward				NHI:
Mod	afini	I		
	equisi O F	Prescribe	boxes where appropriate)	ialist, or in accordance with a protocol or guideline that has been endorsed
	(and		patient has a diagnosis of narcolepsy and has excessive e months or more	daytime sleepiness associated with narcolepsy occurring almost daily for
		or O	The patient has a multiple sleep latency test with a mea onset rapid eye movement periods	n sleep latency of less than or equal to 10 minutes and 2 or more sleep

	\bigcirc	The patient has at least one of:	cataplexy, sle	eep paralysis or hy	pnagogic hallucinations
--	------------	----------------------------------	----------------	---------------------	-------------------------

	\bigcirc	An effective dose of a listed formulation of methylphenic	late or	dexamphetamine	has b	een trialled and	discontinued	because of
		intolerable side effects						
or	_							

O Methylphenidate and dexamphetamine are contraindicated

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:		

Lisdexamfetamine dimesilate

INITIATION

Prerequisites (tick boxes where appropriate)

()Prescribed by, or recommended by a paediatrician or psychiatrist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and

(and	С	ADHD	(Attention Deficit and Hyperactivity Disorder)
and (С	Diagno	osed according to DSM-V or ICD 11 criteria
			Patient is taking a currently subsidised formulation of atomoxetine or methylphenidate hydrochloride (extended-release and has not received sufficient benefit or has experienced intolerable side effects
	or		Patient is taking a currently subsidised formulation of dexamfetamine sulfate (immediate-release) which has not been effective due to significant administration and/or treatment adherence difficulties
	or or	О	There is significant concern regarding the risk of diversion or abuse of immediate release dexamfetamine sulfate
			Patient is taking a currently subsidised formulation of methylphenidate hydrochloride (immediate-release or sustained release) which has not been effective due to significant administration and/or treatment adherence difficulties
	or or	О	There is significant concern regarding the risk of diversion or abuse of immediate release methylphenidate hydrochlorid
		and	O Patient would have been prescribed a subsidised formulation of methylphenidate hydrochloride (extended-releas but has been unable to access due to supply issues with methylphenidate hydrochloride (extended-release)
		und	O Other alternative stimulant presentations (methylphenidate or dexamfetamine) are not appropriate

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:		
Meth	ylp	heni	date	hydrochloride			
				(immediate-release and sustained-release formulatio ox where appropriate)	ns)		
) and	С			by, or recommended by a paediatrician or psychiatrist, or lospital.	in accordance with a protocol or guideline that has been endorsed by the		
and	C	Patier	nt has	ADHD (Attention Deficit and Hyperactivity Disorder), diag	nosed according to DSM-IV or ICD 10 criteria		
				epsy (immediate-release and sustained-release formo	ulations)		
(O Prescribed by, or recommended by a neurologist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.						
	O Patient suffers from narcolepsy						
	equi	sites (tick b	led-release and modified-release formulations oxes where appropriate)	in accordance with a protocol or guideline that has been endorsed by the		
and	_			Hospital.	in accordance with a protocol of guideline that has been chuoised by the		
	and		Patier	nt has ADHD (Attention Deficit and Hyperactivity Disorder), diagnosed according to DSM-IV or ICD 10 criteria		
		or	0	Patient is taking a currently listed formulation of methylph has not been effective due to significant administration a	nenidate hydrochloride (immediate-release or sustained-release) which nd/or compliance difficulties		
O There is significant concern regarding the risk of diversion or abuse of immediate-release methylphenidate hydrochloride							

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:			
Dexam	phetamine sulphate				
	ON – ADHD isites (tick box where appropriate)				
	O Prescribed by, or recommended by a paediatrician or psychiatrist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
Patient has ADHD (Attention Deficit and Hyperactivity Disorder), diagnosed according to DSM-IV or ICD 10 criteria					
	ON – Narcolepsy				
Prerequ	iisites (tick box where appropriate)				
0	Prescribed by, or recommended by a neurologist or respiratory spec by the Health NZ Hospital.	sialist, or in accordance with a protocol or guideline that has been endorsed			
O Patient suffers from narcolepsy					

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:
Rivastigmine	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Image: Constraint of the patient has been diagnosed with dementia and Image: Constraint of 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) O The treatment remains appropriate and O The patient has demonstrated a significant and sustained ben	efit from 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

PRESCRIBER	PATIENT:
Jame:	Name:
Vard:	NHI:
altrexone hydrochloride	
INITIATION – Alcohol dependence	
Prerequisites (tick boxes where appropriate)	
and	s planned to be enrolled, in a recognised comprehensive treatment programme for alcohol dependence y, or on the recommendation of, a physician working in an Alcohol and Drug Service
INITIATION – Constipation Prerequisites (tick box where appropriate)	
O For the treatment of opioid-induced co	nstination

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	CRI	BER		PATIENT:
Name	:			Name:
Ward:				NHI:
Nico	tine	9		
INITI Prere			(tick boxes where appropriate)	
	or		For perioperative use in patients who have a 'nil by mouth' inst	ruction
	or	0	For use within mental health inpatient units	
	or	Ο	Patient would be admitted to a mental health inpatient unit, but	t is unable to due to COVID-19 self-isolation requirement
		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

TIATIO erequis		(tick boxes where appropriate)		
	Ο	Short-term therapy as an aid to achieving abstinence in a patient who has indicated that they are ready to cease smoking		
and	0	The patient is part of, or is about to enrol in, a comprehensive support and counselling smoking cessation programme, which includes prescriber or nurse monitoring		
		O The patient has tried but failed to quit smoking after at least two separate trials of nicotine replacement therapy, at least one of which included the patient receiving comprehensive advice on the optimal use of nicotine replacement therapy		
	or	O The patient has tried but failed to quit smoking using bupropion or nortriptyline		
and	Ο	The patient has not had a Special Authority for varenicline approved in the last 6 months		
and	0	Varenicline is not to be used in combination with other pharmacological smoking cessation treatments and the patient has agreed to this		
	Ο	The patient is not pregnant		
O The patient will not be prescribed more than 12 weeks' funded varenicline in a 12 month period		The patient will not be prescribed more than 12 weeks' funded varenicline in a 12 month period		

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:
Buprenorphine with naloxone	
INITIATION – Detoxification Prerequisites (tick boxes where appropriate) O Patient is opioid dependent and O Patient is currently engaged with an opioid treatment service a and O Prescriber works in an opioid treatment service approved by the	
INITIATION – Maintenance treatment Prerequisites (tick boxes where appropriate)	
O Patient is opioid dependent	
O Patient will not be receiving methadone	
And O Patient is currently enrolled in an opioid substitution treatment and O Prescriber works in an opioid treatment service approved by th	

Oncology Agents and Immunosuppressants

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.

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:			Name:
Ward:			NHI:
Bendam	ustine h	ydrochloride - continued	
Re-assess	sment requ	ndolent, Low-grade lymphomas uired after 9 months poxes where appropriate)	
	and O	Patient is refractory to or has relapsed within 12 months Bendamustine is to be administered in combination with	
or	and	Patients have not received a bendamustine regimen wit	hin the last 12 months

O Bendamustine is to be administered for a maximum of 6 cycles in relapsed patients (in combination with rituximab when CD20+)

Patient has had a rituximab treatment-free interval of 12 months or more

Bendamustine is to be administered as a monotherapy for a maximum of 6 cycles in rituximab refractory patients

Note: 'indolent, low-grade lymphomas' includes follicular, mantle cell, marginal zone and lymphoplasmacytic/ Waldenström's macroglobulinaemia.

INITIATION – Hodgkin's lymphoma*

or

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

and

 \bigcirc

Patient has Hodgkin's lymphoma requiring treatment
 Patient has a ECOG performance status of 0-2
 Patient has received one prior line of chemotherapy
 Patient's disease relapsed or was refractory following prior chemotherapy
 Patient's disease relapsed or was refractory following prior chemotherapy
 Bendamustine is to be administered in combination with gemcitabine and vinorelbine (BeGeV) at a maximum dose of no greater than 90 mg/m2 twice per cycle, for a maximum of four cycles
 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:

Azacitidine

_					
Re-	INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)				
and	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.				
		or or	0 0 0	The patient has International Prognostic Scoring System (IPSS) intermediate-2 or high risk myelodysplastic syndrome The patient has chronic myelomonocytic leukaemia (10%-29% marrow blasts without myeloproliferative disorder) The patient has acute myeloid leukaemia with 20-30% blasts and multi-lineage dysplasia, according to World Health Organisation Classification (WHO)	
	and and	Ο		patient has performance status (WHO/ECOG) grade 0-2 patient has an estimated life expectancy of at least 3 months	
CO)N		

ONTINUATION

Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)

and \bigcirc

O No evidence of disease progression

The treatment remains appropriate and patient is benefitting from 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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Mercaptopurine	
INITIATION Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a paediatric haematologist or pa been endorsed by the Health NZ Hospital. and O The patient requires a total dose of less than one full 50 mg tablet p	ediatric oncologist, or in accordance with a protocol or guideline that has
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a paediatric haematologist or pabeen endorsed by the Health NZ Hospital. and O The patient requires a total dose of less than one full 50 mg tablet pairs	ediatric oncologist, 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.	

ESCRIBER PATIENT:		
ame: Name:		
Vard: NHI:		
/enetoclax		
INITIATION – relapsed/refractory chronic lymphocytic leukaemia		
Re-assessment required after 7 months Prerequisites (tick boxes where appropriate)		
\sim		
 Prescribed by, or recommended by a haematologist, or in accordance Hospital. and 	e with a protocol or guideline that has been endorsed by the Health NZ	
O Patient has chronic lymphocytic leukaemia requiring treatment and		
O Patient has received at least one prior therapy for chronic lymp	phocytic leukaemia	
O Patient has not previously received funded venetoclax and		
The patient's disease has relapsed within 36 months of previo	us treatment	
	rituximab commencing after the 5-week dose titration schedule with	
O Patient has an ECOG performance status of 0-2		
CONTINUATION – relapsed/refractory chronic lymphocytic leukaemia		
Re-assessment required after 6 months		
Prerequisites (tick boxes where appropriate)		
O 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 Treatment remains clinically appropriate and the patient is ben	efitting from and tolerating treatment	
And Venetoclax is to be discontinued after a maximum of 24 month is required due to disease progression or unacceptable toxicity	s of treatment following the titration schedule unless earlier discontinuation	
INITIATION – previously untreated chronic lymphocytic leukaemia with 1 Re-assessment required after 6 months	7p deletion or TP53 mutation*	
Prerequisites (tick boxes where appropriate)		
O 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	
Patient has previously untreated chronic lymphocytic leukaemi	a	
O There is documentation confirming that patient has 17p deletion	n by FISH testing or TP53 mutation by sequencing	
O Patient has an ECOG performance status of 0-2		
CONTINUATION – previously untreated chronic lymphocytic leukaemia v	vith 17p deletion or TP53 mutation*	
Re-assessment required after 6 months Prerequisites (tick box where appropriate)		
Hospital.	e with a protocol or guideline that has been endorsed by the Health NZ	
O The treatment remains clinically appropriate and the patient is benef Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymp 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.

PRESC	RIBER	PATIENT:
Name:		Name:
Ward:		NHI:

Olaparib

		t required after 12 months (tick boxes where appropriate)
	Presc Hospi	cribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health Na ital.
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
and		
		O Patient has newly diagnosed, advanced disease
		O Patient has received one line** of previous treatment with platinum-based chemotherapy
		Patient's disease must have experienced a partial or complete response to the first-line platinum-based regimen
	or	
		O Patient has received at least two lines** of previous treatment with platinum-based chemotherapy and
		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
		And O Patient's disease must have experienced a partial or complete response to treatment with the immediately preceding platinum-based regimen
		and O Patient has not previously received funded olaparib treatment
and		
and		Treatment will be commenced within 12 weeks of the patient's last dose of the immediately preceding platinum-based regimen
anu	\cap	Treatment to be administered as maintenance treatment
and		Treatment not to be administered in combination with other chemotherapy

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:
Olap	arib	- CO	ontinued
			DN – Ovarian cancer It required after 12 months
			(tick boxes where appropriate)
(and		resc lospi	cribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.
	(and	С	Treatment remains clinically appropriate and patient is benefitting from treatment
		or	 No evidence of progressive disease Evidence of residual (not progressive) disease and the patient would continue to benefit from treatment in the clinician's opinion
	and (and (and		Treatment to be administered as maintenance treatment Treatment not to be administered in combination with other chemotherapy
		or	Patient has received one line** of previous treatment with platinum-based chemotherapy and Documentation confirming that the patient has been informed and acknowledges that the funded treatment period of olaparib will not be continued beyond 2 years if the patient experiences a complete response to treatment and there is no radiological evidence of disease at 2 years
			O Patient has received at least two lines** of previous treatment 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.

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:
Ibrutinib	

and	D Patient has chronic lymphocytic leukaemia (CLL) requiring therapy
and	D Patient has not previously received funded ibrutinib
and	D Ibrutinib is to be used as monotherapy
	O There is documentation confirming that patient has 17p deletion or TP53 mutation
	and O Patient has experienced intolerable side effects with venetoclax monotherapy
o	or
	O Patient has received at least one prior immunochemotherapy for CLL and
	Patient's CLL has relapsed within 36 months of previous treatment
	and O Patient has experienced intolerable side effects with venetoclax in combination with rituximab regimen
o	or O Patient's CLL is refractory to or has relapsed within 36 months of a venetoclax regimen
τινιιάτι	TION – chronic lymphocytic leukaemia (CLL)
	nent required after 12 months

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL) and B-cell prolymphocytic leukaemia (B-PLL)*. 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:

Niraparib

INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)				
and and and and and and		Patient has advanced high-grade serous* epithelial ovarian, fallopian tube, or primary peritoneal cancer Patient has received at least one line** of treatment with platinum-based chemotherapy Patient has experienced a partial or complete response to the preceding treatment with platinum-based chemotherapy Patient has not previously received funded treatment with a PARP inhibitor O Treatment will be commenced within 12 weeks of the patient's last dose of the preceding platinum-based regimen O Patient commenced treatment with niraparib prior to 1 May 2024 Treatment to be administered as maintenance treatment Treatment not to be administered in combination with other chemotherapy		
	sites	DN It required after 6 months (tick boxes where appropriate) No evidence of progressive disease Treatment to be administered as maintenance treatment Treatment not to be administered in combination with other chemotherapy O Treatment with niraparib to cease after a total duration of 36 months from commencement O Treatment with niraparib is being used in the second-line or later maintenance setting		

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

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	:	Name:
Ward:		NHI:
Lena	lidomide	
	ATION – Plasma cell dyscrasia equisites (tick boxes where appropriate)	
(and	Prescribed by, or recommended by any relevant practitioner, or in ac NZ Hospital.	cordance with a protocol or guideline that has been endorsed by the Health
	O Patient has plasma cell dyscrasia, not including Waldenström	macroglobulinaemia, requiring treatment
	O Patient is not refractory to prior lenalidomide use	
Re-a	ATION – Myelodysplastic syndrome ssessment required after 6 months equisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in ac NZ Hospital.	cordance with a protocol or guideline that has been endorsed by the Health
	O Patient has low or intermediate-1 risk myelodysplastic syndror a deletion 5q cytogenetic abnormality and	ne (based on IPSS or an IPSS-R score of less than 3.5) associated with
	O Patient has transfusion-dependent anaemia	
Re-a	TINUATION – Myelodysplastic syndrome ssessment required after 12 months equisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in ac NZ Hospital. O Patient has not needed a transfusion in the last 4 months and	cordance with a protocol or guideline that has been endorsed by the Health
	O No evidence of disease progression	

and

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and \bigcirc

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:
Pomalidomide	
INITIATION – Relapsed/refractory plasma cell dyscrasia 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 by the Health NZ Hospital.

O Patient has relapsed or refractory plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment

Patient has not received prior funded pomalidomide

CONTINUATION - Relapsed/refractory plasma cell dyscrasia

Re-assessment required after 12 months

Prerequisites (tick box 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 has no evidence of disease progression

I confirm that the above details are correct:

Signed: Date:

Name:	. Name:
Ward:	. NHI:
Temozolomide	
INITIATION – gliomas Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Patient has a glioma	
CONTINUATION – gliomas Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Treatment remains appropriate and patient is benefitting from treat	tment
INITIATION – Neuroendocrine tumours Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)	
 Patient has been diagnosed with metastatic or unresectable and Temozolomide is to be given in combination with capecitable and Temozolomide is to be used in 28 day treatment cycles for a per day 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 benefi	tting 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)	
O No evidence of disease progression and O The treatment remains appropriate and the patient is benefi	tting from 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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Thalidomide	
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	

The patient has plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment

The patient has erythema nodosum leprosum

CONTINUATION

or

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

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)

m O The patient has plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring 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:
Pegaspargase	
INITIATION – Newly diagnosed ALL Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
O The patient has newly diagnosed acute lymphoblastic leukaer and O Pegaspargase to be used with a contemporary intensive multi	
INITIATION – Relapsed ALL Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
O The patient has relapsed acute lymphoblastic leukaemia and O 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)

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	ENT:
Name:	Nam	e:
Ward:	NHI:	

Nilotinib

INITIATION Re-assessment required after 6 months 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	O Patient has a diagnosis of chronic myeloid leukaemia (CML) in blast crisis, high risk chronic phase, or in chronic phase	
		O Patient has documented CML treatment failure* with a tyrosine kinase inhibitor (TKI)	
		O Patient has experienced treatment limiting toxicity with a tyrosine kinase inhibitor (TKI) precluding further treatment	
	and and	O Maximum nilotinib dose of 800 mg/day	
	anu	O Subsidised for use as monotherapy only	
Note	: *trea	atment failure as defined by Leukaemia Net Guidelines.	
Re-a	ssess	ATION ment required after 6 months ites (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	O Lack of treatment failure while on nilotinib as defined by Leukaemia Net Guidelines	
	and	O Nilotinib treatment remains appropriate and the patient is benefiting from treatment	
	and	O Maximum nilotinib dose of 800 mg/day	
		${\sf O}$ Subsidised for use as monotherapy only	

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:

Ruxolitinib

INITIA Re-as			t required after 12 months			
Prere	quisi	tes	(tick boxes where appropriate)			
and		'reso losp	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 primary myelofibrosis or post-polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis and					
		or	A classification of risk of intermediate-2 or high-risk myelofibrosis according to either the International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or the Age-Adjusted DIPSS or			
			A classification of risk of intermediate-1 myelofibrosis according to either the International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or the Age-Adjusted DIPSS and			
			O Patient has severe disease-related symptoms that are resistant, refractory or intolerant to available therapy			
	and (С	A maximum dose of 20 mg twice daily is to be given			
СОИТ	ΓΙΝυ		N			

Re-assessment required after 12 months **Prerequisites** (tick boxes where appropriate)

and \bigcirc

O The treatment remains appropriate and the patient is benefiting from treatment

A maximum dose of 20 mg twice daily is to be given

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) Image: O Patient has locally advanced, or metastatic, unresectable, non and O There is documentation confirming that the patient has an ALF 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)	eria

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:

Palbociclib (Ibrance)

	(and	С	Patient has unresectable locally advanced or metastatic breast cancer
		O There is documentation confirming disease is hormone-receptor positive and HER2-negative	
	and (and	С	Patient has an ECOG performance score of 0-2
Disease has relapsed or progressed during prior endocrine therapy			O 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 treatment for metastatic disease
	and (and	С С	Treatment must be used in combination with an endocrine partner Patient has not received prior funded treatment with a CDK4/6 inhibitor
or			
	and	\mathcal{O}	Patient has an active Special Authority approval for ribociclib
	and	С	Patient has experienced a grade 3 or 4 adverse reaction to ribociclib that cannot be managed by dose reductions and requires treatment discontinuation
	and	С	Treatment must be used in combination with an endocrine partner
		С	There is no evidence of progressive disease since initiation of ribociclib

Prerequisites (tick boxes where appropriate)

Ο and \bigcirc

Treatment must be used in combination with an endocrine partner

There is no evidence of progressive disease since initiation of palbociclib

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.

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:	

Ribociclib

INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)								
	and and and	0 0 0	 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 					
	and and and and	or	 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 and O Patient has not received prior systemic endocrine treatment for metastatic disease 					
		or	O Patient commenced treatment with ribociclib in combination with an endocrine partner prior to 1 July 2024 and O There is no evidence of progressive disease Treatment to be used in combination with an endocrine partner					
or		0	Patient has not received prior funded treatment with a CDK4/6 inhibitor 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					
Re-assess	CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Treatment must be used in combination with an endocrine partner							
and								

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:		

Lenvatinib

or	O Patient is currently on treatment with lenvatinib and met all remaining criteria prior to commencing treatment							
	and	O The patient has locally advanced or metastatic differentiated thyroid cancer						
	und		0	Patient must have symptomatic progressive disease prior to treatment				
		or	0	Patient must progressive disease at critical anatomical sites with a high risk of morbidity or mortality where local control cannot be achieved by other measures				
	and							
			Ο	A lesion without iodine uptake in a RAI scan				
		or	Ο	Receiving cumulative RAI greater than or equal to 600 mCi				
		or	Ο	Experiencing disease progression after a RAI treatment within 12 months				
		or	Ο	Experiencing disease progression after two RAI treatments administered within 12 months of each other				
	and	$\overline{\mathbf{O}}$	Patie	ent has thyroid stimulating hormone (TSH) adequately supressed				
	and	\bigcirc						
	and	\bigcirc	Patie	ent is not a candidate for radiotherapy with curative intent				
		\bigcirc	Surg	ery is clinically inappropriate				
	and	\bigcirc	O Patient has an ECOG performance status of 0-2					

Prerequisites (tick box where appropriate)

O There is no evidence 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:							
Lenvatinib - continued								
INITIATION – unresectable hepatocellular carcinoma Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)								
 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 O Patient has not received prior systemic therapy for their or								
Patient has experienced treatment-limiting toxicity and No disease progression since initiation of atezoliz	y from treatment with atezolizumab with bevacizumab							
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 								
And O Patient has experienced treatment limiting toxicity from	or the second line treatment of metastatic renal cell carcinoma treatment with nivolumab							
and O Lenvatinib is to be used in combination with everolimus and O There is no evidence of disease progression								
CONTINUATION - renal cell carcinoma Re-assessment required after 4 months Prerequisites (tick box where appropriate)								
O There is no evidence 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:

Osimertinib

INITIATION – NSCLC – first line Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)			
(and	С	Patient has locally advanced or metastatic, incurable, non-squamous non-small cell lung cancer (NSCLC)	
	or	O Patient is treatment naïve	
	or	O Patient has received prior treatment in the adjuvant setting and/or while awaiting EGFR results	
		O The patient has discontinued gefitinib or erlotinib due to intolerance	
		O The cancer did not progress while on gefitinib or erlotinib	
and (and	C	There is documentation confirming that the cancer expresses activating mutations of EGFR	
and	С	Patient has an ECOG performance status 0-3	
(С	Baseline measurement of overall tumour burden is documented clinically and radiologically	
Re-assess Prerequisit	men ites Resp	DN - NSCLC - first line t required after 6 months (tick box where appropriate) onse to or stable disease with treatment in target lesions has been determined by comparable radiologic assessment following the most it treatment period	
Re-assess	men	NSCLC – second line t required after 4 months (tick boxes where appropriate)	
(and	С	Patient has locally advanced or metastatic, incurable, non-squamous non-small cell lung cancer (NSCLC)	
and	С	Patient has an ECOG performance status 0-3	
(and	С	The patient must have received previous treatment with erlotinib or gefitinib	
(С	There is documentation confirming that the cancer expresses T790M mutation of EGFR following progression on or after erlotinib or gefitinib	
and (С	The treatment must be given as monotherapy	
and	С	Baseline measurement of overall tumour burden is documented clinically and radiologically	
	ATIC		

CONTINUATION – NSCLC – second line Re-assessment required after 6 months

Prerequisites (tick box where appropriate)

()

Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period

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:	Name:
Ward:	NHI:

Dasatinib

	ION essment required after 6 months uisites (tick boxes where appropriate)		
O and	Prescribed by, or recommended by a haematologist or any relevant practitioner on the recommendation of a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
o	\sim		
o			
	and O The patient has a diagnosis of CML in chronic phase O Patient has documented treatment failure* with imatinib		
	or O Patient has experienced treatment-limiting toxicity 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 practitioner on the recommendation of a haematologist , or in accordance			
and	with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
a	O Lack of treatment failure while on dasatinib* nd O Dasatinib treatment remains appropriate and the patient is benefiting from treatment		
Note:	treatment failure for CML as defined by Leukaemia Net Guidelines.		

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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:
• • • • •	

Erlotinib

	N ment required after 4 months ites (tick boxes where appropriate)	
and and	 Patient has locally advanced or metastatic, unresectable, non-squamous Non Small Cell Lung Cancer (NSCLC) There is documentation confirming that the disease expresses activating mutations of EGFR 	
	O Patient is treatment naive or O Patient has received prior treatment in the adjuvant setting and/or while awaiting EGFR results or O The patient has discontinued osimertinib or getitinib due to intolerance and O The cancer did not progress while on osimertinib or gefitinib	

CONTINUATION

Re-assessment required after 6 months

Prerequisites (tick box where appropriate)

O Radiological assessment (preferably including CT scan) indicates NSCLC has not progressed

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:	Name:
Ward:	NHI:

Sunitinib

NITIATION – RCC Re-assessment required after 3 months Prerequisites (tick boxes where appropriate)			
and	0	The patient has metastatic renal cell carcinoma of predominantly clear cell histology	
una	or	O The patient is treatment naive	
	or	O The patient has only received prior cytokine treatment	
	or O The patient has only received prior treatment with an investigational agent within the confines of a bona fide clinical trial which has Ethics Committee approval		
	-	O The patient has discontinued pazopanib within 3 months of starting treatment due to intolerance and	
		The cancer did not progress whilst on pazopanib	
and and	0	The patient has an ECOG performance score of 0-2 Sunitinib to be used for a maximum of 2 cycles	
Re-assess Prerequis	smer ites	DN – RCC It required after 3 months (tick box where appropriate) vidence of disease progression	
	mer	GIST It required after 3 months (tick boxes where appropriate)	
and	0	The patient has unresectable or metastatic malignant gastrointestinal stromal tumour (GIST)	
	or	O The patient's disease has progressed following treatment with imatinib	
		O The patient has documented treatment-limiting intolerance, or toxicity to, imatinib	

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		

CONTINUATION – GIST

The ollows	•	nt has responded to treatment or has stable disease as determined by Choi's modified CT response evaluation criteria
	Ο	The patient has had a complete response (disappearance of all lesions and no new lesions)
0	0	The patient has had a partial response (a decrease in size of 10% or more or decrease in tumour density in Hounsfield Units (HU) of 15% or more on CT and no new lesions and no obvious progression of non-measurable disease)
0	0	The patient has stable disease (does not meet criteria the two above) and does not have progressive disease and no symptomatic deterioration attributed to tumour progression

CONTINUATION – GIST pandemic circumstances Re-assessment required after 6 months

and

and ()

and

Prerequisites (tick boxes where appropriate)

The patient has unresectable or metastatic malignant gastrointestinal stromal tumour (GIST)

The patient is clinically benefiting from treatment and continued treatment remains appropriate

Sunitinib is to be discontinued at progression

The regular renewal requirements cannot be met due to COVID-19 constraints on the health sector

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:

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:
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 II and The cancer has not progressed at any time point during the pr and	
Lapatinib not to be given in combination with trastuzumab and Lapatinib to be discontinued at 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:

Pazopanib

	ment r		ired after 3 months oxes where appropriate)
	(and	С	The patient has metastatic renal cell carcinoma of predominantly clear cell histology
		or	O The patient is treatment naive
			O The patient has only received prior cytokine treatment
	and (and	С	The patient has an ECOG performance score of 0-2
	ר	[he	patient has intermediate or poor prognosis defined as:
		or	O Lactate dehydrogenase level > 1.5 times upper limit of normal
		or	O Haemoglobin level < lower limit of normal
		or	Corrected serum calcium level > 10 mg/dL (2.5 mmol/L)
		or	O Interval of < 1 year from original diagnosis to the start of systemic therapy
		or	O Karnofsky performance score of less than or equal to 70
			O 2 or more sites of organ metastasis
or	(С	The patient has metastatic renal cell carcinoma
	and (С	The patient has discontinued sunitinib within 3 months of starting treatment due to intolerance
	and (and	С	The cancer did not progress whilst on sunitinib
		С	Pazopanib to be used for a maximum of 3 months
CONTINUA Re-assess			ired after 3 months

Prerequisites (tick box where appropriate)

O No evidence of disease progression

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:	Name:
Ward:	NHI:

Gefitinib

INITIATION Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)
O Patient has locally advanced, or metastatic, unresectable, non-squamous Non Small Cell Lung Cancer (NSCLC)
O Patient is treatment naive
or O Patient has received prior treatment in the adjuvant setting and/or while awaiting EGFR results or
O The patient has discontinued osimertinib or erlotinib due to intolerance and
O The cancer did not progress whilst on osimertinib or erlotinib
and O 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 NSCLC has not progressed

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:
Dexrazoxane	
INITIATION	

Prer	Prerequisites (tick boxes where appropriate)				
(and	O Prescribed by, or recommended by a medical oncologist, paediatric oncologist, haematologist or paediatric haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
	(and	С	Patient is to receive treatment with high dose anthracycline given with curative intent		
	(С	Based on current treatment plan, patient's cumulative lifetime dose of anthracycline will exceed 250mg/m2 doxorubicin equivalent or greater		
	and (С	Dexrazoxane to be administered only whilst on anthracycline treatment		
	and	_			
			O Treatment to be used as a cardioprotectant for a child or young adult		
		or	O Treatment to be used as a cardioprotectant for secondary malignancy		
L	\square				

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:

Abiraterone acetate

	ssmen	t required after 6 months (tick boxes where appropriate)
O		ribed by, or recommended by a medical oncologist, radiation oncologist or urologist, or in accordance with a protocol or guideline that has endorsed by the Health NZ Hospital.
an	O d	Patient has prostate cancer
an	d b	Patient has metastases
an	d 	Patient's disease is castration resistant
		O Patient is symptomatic
		O Patient has disease progression (rising serum PSA) after second line anti-androgen therapy and
		O Patient has ECOG performance score of 0-1 and
	or	O Patient has not had prior treatment with taxane chemotherapy
		O Patient's disease has progressed following prior chemotherapy containing a taxane
		O Patient has ECOG performance score of 0-2
		O Patient has not had prior treatment with abiraterone
\subseteq		

CONTINUATION

CONTINUATION
Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)

and	С		cribed by, or recommended by a medical oncologist, radiation oncologist or urologist, or in accordance with a protocol or guideline that has endorsed by the Health NZ Hospital.
		0	Significant decrease in serum PSA from baseline
	and	Ο	No evidence of clinical disease progression
		Ο	No initiation of taxane chemotherapy with abiraterone
	and	O	The treatment remains appropriate and the patient is benefiting from 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.

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

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:

Fulvestrant

	isses	smen	It required after 6 months (tick boxes where appropriate)
and		Preso Hosp	cribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.
	anc anc anc		Patient has oestrogen-receptor positive locally advanced or metastatic breast cancer Patient has disease progression following prior treatment with an aromatase inhibitor or tamoxifen for their locally advanced or metastatic disease Treatment to be given at a dose of 500 mg monthly following loading doses Treatment to be discontinued at disease progression

CONTINUATION

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

(and		Prescribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health N Hospital.					
		0	Treatment remains appropriate and patient is benefitting from treatment				
	anc	0	Treatment to be given at a dose of 500 mg monthly				
	anc	\Box	No evidence 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:

Long-acting Somatostatin Analogues

	INITIATION – Malignant bowel obstruction Prerequisites (tick boxes where appropriate)				
O The patient has nausea* and vomiting* due to malignant bowel obstruction*					
	and	0	Treatment with antiemetics, rehydration, antimuscarinic agents, corticosteroids and analgesics for at least 48 hours has not been successful		
	anu	Ο	Treatment to be given for up to 4 weeks		
Note	: Indie	catio	ns marked with * are unapproved indications		
INITIATION – acromegaly Re-assessment required after 3 months Prerequisites (tick boxes where appropriate)					
O The patient has acromegaly and					
			O Treatment with surgery and radiotherapy is not suitable or was unsuccessful		
		or	O Treatment is for an interim period while awaiting the beneficial effects of radiotherapy		
	and O Treatment with a dopamine agonist has been unsuccessful				

CONTINUATION – acromegaly

Prerequisites (tick box where appropriate)

O Without reassessment for applications where IGF1 levels have decreased since starting treatment

Note: In patients with acromegaly, treatment should be discontinued if IGF1 levels have no decreased 3 months after treatment. In patients treated with radiotherapy treatment should be withdrawn every 2 years, for 1 month, for assessment of remission. Treatment should be stopped where there is biochemical evidence of remission (normal IGF1 levels) following treatment withdrawal for at least 4 weeks.

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.

PRESCRI	BER PATIENT:
Name:	Name:
Ward:	NHI:
Long-ac	ting Somatostatin Analogues - continued
	DN – Other indications sites (tick boxes where appropriate)
or	O VIPomas and glucagonomas - for patients who are seriously ill in order to improve their clinical state prior to definitive surgery
	O Gastrinoma and
	O Surgery has been unsuccessful
	O Patient has metastatic disease after treatment with H2 antagonist or proton pump inhibitors has been unsuccessful
or	
	O Insulinomas
	O Surgery is contraindicated or has not been successful
or	O For pre-operative control of hypoglycaemia and for maintenance therapy
	O Carcinoid syndrome (diagnosed by tissue pathology and/or urinary 5HIAA analysis)
	O Disabling symptoms not controlled by maximal medical therapy

INITIATION – pre-operative acromegaly Re-assessment required after 12 months

Prerequisites	(tick boxes	where	appropriate))
---------------	-------------	-------	--------------	---

	0	Patient has acromegaly
	and	Patient has a large pituitary tumour, greater than 10 mm at its widest
	and	Patient is scheduled to undergo pituitary surgery in the next six months
Note:	Indicatio	ons marked with * are unapproved indications
Note:	The use	of a long-acting somatostatin analogue in patients with fistulae, oesophageal varices, miscellaneous diarrhoea and hypotension will not be
		Special Authority

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:			
Aminolevulinic acid hydrochloride				
INITIATION – high grade malignant glioma Prerequisites (tick boxes where appropriate)				
O Patient has newly diagnosed, untreated, glioblastoma multiform	me			
O Treatment to be used as adjuvant to fluorescence-guided rese	ction			
Patient's tumour is amenable to complete resection				

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:
Tacrolimus	
INITIATION – organ transplant recipients	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by any specialist, or in accordance Hospital.	with a protocol or guideline that has been endorsed by the Health NZ
O For use in organ transplant recipients	
INITIATION – non-transplant indications* Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by any specialist, or in accordance Hospital.	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 treatmen	t because of unacceptable side effects or inadequate clinical response
O Patient is a child with nephrotic syndrome*	
Note: Indications marked with * are unapproved indications	

RS2062 - Etanercept

Arthritis - rheumatoid - INITIATION Arthritis - rheumatoid - CONTINUATION	
Adult-onset Still's disease - INITIATION Adult-onset Still's disease - CONTINUATION	
Ankylosing spondylitis - INITIATION	
Ankýlosing spondylitis - CONTINUATION Oligoarticular course juvenile idiopathic arthritis - INITIATION	
Oligoarticular course juvenile idiopathic arthritis - CONTINUATION Polyarticular course juvenile idiopathic arthritis - INITIATION	
Polyarticular course juvenile idiopathic arthritis - CONTINUATION Psoriatic arthritis - INITIATION	
Psoriatic arthritis - CONTINUATION	
Pyoderma gangrenosum - INITIATION Pyoderma gangrenosum - CONTINUATION	
Severe chronic plaque psoriasis - CONTINUATION Severe chronic plaque psoriasis, prior TNF use - INITIATION	
Severe chronic plaque psoriasis, treatment-naive - INITIATION Undifferentiated spondyloarthritis - INITIATION	
Undifferentiated spondyloarthritis - CONTINUATION	

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:		
Name	ə:			Name:		
Ward	:			NHI:		
Etan	erce	ept				
Re-a	assess requis	sment sites († Prescr	requ tick b ibed	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	0	The patient has had an initial Special Authority approval for adalimumab for polyarticular course juvenile idiopathic arthritis (JIA)		
		and	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 polyarticular course JIA 		
	or					
		and	0 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		
			or	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)		
			or	O Low disease activity (cJADAS10 score between 1.1 and 2.5) after a 6-month trial of methotrexate		
Re-a	assess	sment	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	i		ment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or rance		
		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		
O 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						

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:
Etanercept - continued	
INITIATION – oligoarticular course juvenile idiopathic arthritis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	ecialist, 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 approva (JIA)	al for adalimumab for oligoarticular course juvenile idiopathic arthritis
O The patient has experienced intolerable side effe	ects from adalimumab a adalimumab to meet the renewal criteria for adalimumab for
and Patient has had oligoarticular course JIA for 6 months and At least 2 active joints with limited range of motion maximum tolerated dose)	on, pain or tenderness after a 3-month trial of methotrexate (at the ore greater than 1.5) with poor prognostic features after a 3-month trial
CONTINUATION – oligoarticular course juvenile idiopathic arthritis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	

\cup	Prescribed by, or recomme	nded by a rheumatologist	or named specialist, or	in accordance with a protoc	ol or guideline that has been endorse	эd
	by the Health NZ Hospital.					
and	, ,					
	\bigcirc					

Subsidised as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance

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

and

 \mathbf{O}

 \bigcirc

or

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	ł:			NHI:					
Etar	nerce	ept -	conti	nued					
Re-a	assess	sment	requ	is - rheumatoid red after 6 months					
Prei	requis	sites (t	tick b	oxes where appropriate)					
and	O Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by Hospital.								
		and	0	The patient has had an initial Special Authority approval for adalimumab for rheumatoid arthritis					
			or	O The patient has experienced intolerable side effects					
				O The patient has received insufficient benefit to meet the renewal criteria for rheumatoid arthritis					
	or		~						
	 Patient has had rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic citrullinated peptide (C antibody positive) for six months duration or longer Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by to 								
		and	\bigcirc	or intolerance Patient has tried and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated)					
		and	0	Patient has tried and not responded to at least three months of methotrexate in combination with sulfasalazine and hydroxychloroquine					
		and	_	sulphate at maximum tolerated doses (unless contraindicated)					
			or	O Patient has tried and not responded to at least three months of methotrexate in combination with the maximum tolerated dose of ciclosporin					
				O 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		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 from the following: wrist, elbow, knee, ankle, and either shoulder or hip					
Re-a	assess	sment	requ	rthritis - rheumatoid red after 2 years oxes where appropriate)					
and	l	Prescr NZ Ho		by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health .					
	O Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance								

Following initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant

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
 and
 O Etanercept to be administered at doses no greater than 50 mg every 7 days

I confirm that the above details are correct:

()

or

and

Signed: Date:

response to treatment in the opinion of the physician

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	ne Pharmaceutical
Schedule. For community funding, see the Special Authority Criteria.			

PRE	SCRIB	BER		PATIENT:	
Nam	e:			Name:	
Ward	ł:			NHI:	
Etar	nerce	ept -	conti	inued	
				osing spondylitis	
				uired after 6 months poxes where appropriate)	
1101	\sim				
		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					
		and	Ο	The patient has had an initial Special Authority approval for adalimumab for ankylosing spondylitis	
			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 ankylosing spondylitis	
	or	\subseteq			
			Ο	Patient has a confirmed diagnosis of ankylosing spondylitis present for more than six months	
		and	\bigcirc	Patient has low back pain and stiffness that is relieved by exercise but not by rest	
		and		Patient has low back pain and stimless that is relieved by exercise but not by rest	
			\bigcirc	Patient has bilateral sacroiliitis demonstrated by plain radiographs, CT or MRI scan	
And O Patient's ankylosing spondylitis has not responded adequately to treatment with two or more non-steroidal anti-i					
				drugs (NSAIDs), in combination with anti-ulcer therapy if indicated, while patient was undergoing at least 3 months of a regular	
		and		exercise regimen for ankylosing spondylitis	
				O 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	
			or	4 cm and lumbar side flexion measurement of less than or equal to 10 cm (mean of left and right)	
				O 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			
			\bigcirc	Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) of at least 6 on a 0-10 scale	
Note	e: The	BASE	DAI n	nust have been determined at the completion of the 3 month exercise trial, but prior to ceasing NSAID treatment. The BASDAI	
				more than 1 month old at the time of starting treatment.	
Avei	rage no		Age	st expansion corrected for age and gender: Male Female	
			18-2		
			25-3		
			35-4		
			45-5		
			55-6	54 5.5 cm 4.0 cm	

65-74

75+

4.0 cm

3.0 cm

4.0 cm

2.5 cm

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:
Etanercept	- continued
CONTINUATIO Re-assessmen Prerequisites And And And O and	DN – ankylosing spondylitis It required after 6 months (tick boxes where appropriate) cribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
Re-assessmen Prerequisites	t required after 6 months (tick boxes where appropriate) cribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
an	 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 and and	 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

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:
Etan	erc	ept	- cont	inued	
CONTINUATION – psoriatic arthritis Re-assessment required after 6 months Prerequisites (tick boxes 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 0	clinically significant response to treatment in the opinion	rovement in active joint count from baseline and a clinically significant
	and	O	Etan	ercept to be administered at doses no greater than 50 mg	every 7 days
INITIATION – severe chronic plaque psoriasis, prior TNF use Re-assessment required after 4 months Prerequisites (tick boxes where appropriate) O 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					
	anc	O L	The	patient has had an initial Special Authority approval for ad	alimumab for severe chronic plaque psoriasis
		or	0 0	The patient has experienced intolerable side effects from The patient has received insufficient benefit from adalism plaque psoriasis	n adalimumab umab to meet the renewal criteria for adalimumab for severe chronic
	anc	С ^в О	Patie	ent must be reassessed for continuation after 3 doses	

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		F	PATIENT:		
Name	:			N	lame:		
Ward				N	IHI:		
Etan	erce	pt -	- conti	inued			
				e chronic plaque psoriasis, treatment-naive ired after 4 months			
				poxes where appropriate)			
(and		Presc lospi		by, or recommended by a dermatologist, or in accordance w	with a protocol or guideline that has been endorsed by the Health NZ		
	Patient has "whole body" severe chronic plaque psoriasi 10, where lesions have been present for at least 6 month				with a Psoriasis Area and Severity Index (PASI) score of greater than from the time of initial diagnosis		
		or	Ο	Patient has severe chronic plaque psoriasis of the face, or been present for at least 6 months from the time of initial d	palm of a hand or sole of a foot, where the plaque or plaques have liagnosis		
			Ο		ue psoriasis where the plaques or lesions have been present for at a Dermatology Life Quality Index (DLQI) score greater than 10		
	and (and	С		nt has tried, but had an inadequate response (see Note) to, ving (at maximum tolerated doses unless contraindicated):	or has experienced intolerable side effects from, at least three of the phototherapy, methotrexate, ciclosporin, or acitretin		
	(С	treatr		assessment has been completed for at least the most recent prior ferably while still on treatment but no longer than 1 month following		
	and	С	The n	most recent PASI or DLQI assessment is no more than 1 m	onth old at the time of initiation		
while	still c	n tre	eatmer	nt but no longer than 1 month following cessation of the mo	Je psoriasis, a PASI score of greater than 10, as assessed preferably ost recent prior treatment; for severe chronic plaque psoriasis of the cores for erythema, thickness and scaling are rated as severe or very		

face, hand, foot, genital or flexural areas at least 2 of the 3 PASI symptom subscores for erythema, thickness 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 more of the face, palm 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 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:		

Etanercept - continued

CONTINUATION – severe chronic plaque psoriasis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)

	and	O Patient had "whole body" severe chronic plaque psoriasis at the start of treatment				
		 Following each prior etanercept 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-etanercept treatment baseline value Following each prior etanercept 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				
		O Following each prior etanercept 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				
		• O Following each prior etanercept 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-etanercept treatment baseline value				
or						
	and	O Patient had severe chronic localised genital or flexural plaque psoriasis at the start of treatment				
		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				
		O Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing etanercept				
and						
O	Etaner	cept to be administered at doses no greater than 50 mg every 7 days				
TIATION -	pyoderi	ma gangrenosum				
erequisites	(tick bo	xes where appropriate)				
Hosp		y, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ				
d O	Patient	t has pyoderma gangrenosum*				
and						
U		t has received three months of conventional therapy including a minimum of three pharmaceuticals (e.g. prednisone, ciclosporil oprine, or methotrexate) and not received an adequate response				

Note: Indications marked with * are unapproved indications.

O A maximum of 8 doses

and

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:				
Etan	erce	pt-a	conti	linued				
CON	TINU		l – p	oyoderma gangrenosum				
Prere	equisi	tes (t	ick b	boxes where appropriate)				
and	O Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorse Hospital.							
	(and	D f	Patie	ent has shown clinical improvement				
	(Э ғ	Patie	ent continues to require treatment				
	and (C A	A ma	aximum of 8 doses				
INITIATION – adult-onset Still's disease 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 He Hospital.								
			or	 O The patient has had an initial Special Authority approval for etanercept for adult-onset Still's disease (AOSD) O The patient has been started on tocilizumab for AOSD in a Health NZ Hospital 				
		and	and	or	O The patient has experienced intolerable side effects from etanercept and/or tocilizumab O 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			
	or	and	0 0 0	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 antiinflammatory drugs (NSAIDs) and methotrexate Patient has persistent symptoms of disabling poorly controlled and active disease				
Re-as	ssessi equisi	ment tes (t	requ ick b bed	adult-onset Still's disease uired after 6 months box where appropriate) I by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ				

 \odot The patient has a sustained improvement in inflammatory markers and functional status

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	CRIB	ER		PATIENT:				
Name	:			Name:				
Ward:	Ward: NHI:							
Etan	erce	pt ·	cont	inued				
				erentiated spondyloarthritis uired after 6 months				
				poxes where appropriate)				
(and		Preso Hosp		by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ				
anu	(О		ent 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				
	and (and	О		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	0	Patie dose	ent 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)				
	and (and	0	Patie	ent has tried and not responded to at least three months of leflunomide at a dose of up to 20 mg daily (or maximum tolerated dose)				
		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				
			0	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				
		or	0	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				
Note:	Indic	catio	ns ma	arked with * are unapproved indications.				
Re-a	ssess	men	t requ	Indifferentiated spondyloarthritis hired after 6 months boxes where appropriate)				
		or	Ο	Applicant is a rheumatologist				
			0	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	0	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				
			Ο	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				
	and (O	Etan	ercept to be administered at doses no greater than 50 mg dose every 7 days				

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:	Name:
Ward:	NHI:

Bevacizumab

INITIATION – Recurrent Respiratory Papillomatosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by an otolaryngologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and () Maximum of 6 doses and The patient has recurrent respiratory papillomatosis and () The treatment is for intra-lesional administration **CONTINUATION – Recurrent Respiratory Papillomatosis** Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) () Prescribed by, or recommended by an otolaryngologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and () Maximum of 6 doses and The treatment is for intra-lesional administration and ()There has been a reduction in surgical treatments or disease regrowth as a result of treatment **INITIATION** – ocular conditions

Prerequisites (tick boxes where appropriate)

or

Ocular neovascularisation

Exudative ocular angiopathy

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:		
Ranibizumab			
INITIATION – Wet Age Related Macular Degeneration			

Re-assessment required after 3 months **Prerequisites** (tick boxes where appropriate)

	Prescribed by, or recommended by an ophthalmologist or nurse practitioner, or in accordance with a protocol or guideline that has been	
	endorsed by the Health NZ Hospital.	
and		

	or	 Wet age-related macular degeneration (wet AMD) Polypoidal choroidal vasculopathy
	or	
		O Choroidal neovascular membrane from causes other than wet AMD
and	\geq	
		O The patient has developed severe endophthalmitis or severe posterior uveitis following treatment with bevacizumab
	or	O There is worsening of vision or failure of retina to dry despite three intraocular injections of bevacizumab four weeks apart
and		
and	\mathbf{O}	There is no structural damage to the central fovea of the treated eye
	О	Patient has not previously been treated with aflibercept for longer than 3 months

CONTINUATION – Wet Age Related Macular Degeneration

Re-assessment required after 12 months

 $\label{eq:precession} \textbf{Prerequisites} \ (tick \ boxes \ where \ appropriate)$

and

and

O Prescribed by, or recommended by an ophthalmologist or nurse practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

O 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	323
Crohn's disease (adults) - CONTINUATION	
Crohn's disease (children) - INITIATION	
Crohn's disease (children) - CONTINUATION	
Graft vs host disease - INITIATION	
Inflammatory bowel arthritis (axial) - INITIATION	
Inflammatory bowel arthritis (axial) - CONTINUATION	
Inflammatory bowel arthritis (peripheral) - INITIATION	
Inflammatory bowel arthritis (peripheral) - CONTINUATION	
Pulmonary sarcoidosis - INITIATION	
Acute fulminant ulcerative colitis - INITIATION	
Ankylosing spondylitis - INITIATION	
Ankylosing spondylitis - CONTINUATION	
Chronic ocular inflammation - INITIATION	
Chronic ocular inflammation - CONTINUATION	
Fistulising Crohn's disease - INITIATION	
Fistulising Crohn's disease - CONTINUATION	
Fulminant ulcerative colitis - CONTINUATION	
Neurosarcoidosis - INITIATION	
Neurosarcoidosis - CONTINUATION	
Plaque psoriasis - INITIATION	
Plaque psoriasis - CONTINUATION	
Psoriatic arthritis - INITIATION	
Psoriatic arthritis - CONTINUATION	
Pyoderma gangrenosum - INITIATION	
Pyoderma gangrenosum - CONTINUATION	
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 - CONTINUATION	

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	CRI	BER			PATIENT:
Name	:				Name:
Ward:					NHI:
Inflix	ima	ab			
	equis	sites	(tick b	vs host disease box where appropriate) steroid-refractory acute graft vs. host disease of the gut	
Re-a	sses equis	smen sites	nt requ (tick b	natoid arthritis ired after 4 months poxes where appropriate) by, or recommended by a rheumatologist, or in accordance	ce with a protocol or guideline that has been endorsed by the Health NZ
and		Hosp	oital.	patient has had an initial Special Authority approval for ad	
	and	or	0 0	adalimumab and/or etanercept	or etanercept, the patient did not meet the renewal criteria for
Re-a	sses	smen	intole DN – r l nt requ	ment is to be used as an adjunct to methotrexate therapy erance heumatoid arthritis ired after 6 months boxes where appropriate)	or monotherapy where use of methotrexate is limited by toxicity or
(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
	and	0 I		ment is to be used as an adjunct to methotrexate therapy erance	or monotherapy where use of methotrexate is limited by toxicity or
		or	0 0	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 rovement in active joint count from baseline and a clinically significant
	and	0	Inflixi	mab to be administered at doses no greater than 3 mg/kg	every 8 weeks
Re-a	sses	smen	nt requ	osing spondylitis ired after 3 months boxes 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
	and		The p	patient has had an initial Special Authority approval for ad	alimumab and/or etanercept for ankylosing spondylitis
		or	0	The patient has experienced intolerable side effects from	n a reasonable trial of adalimumab and/or etanercept
			0	Following 12 weeks of adalimumab and/or etanercept tre and/or etanercept for ankylosing spondylitis	eatment, the patient did not meet the renewal criteria for adalimumab

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:
Infliximab - continued	
CONTINUATION – ankylosing spondylitis Re-assessment required after 6 months	
Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a rheumatologist, or in accorda Hospital.	nce with a protocol or guideline that has been endorsed by the Health NZ
$\bigcap_{i=1}^{n}$	roved by 4 or more points from pre-infliximab baseline on a 10 point scale,
O Physician considers that the patient has benefited from treatm	ment and that continued treatment is appropriate
Infliximab to be administered at doses no greater than 5 mg/k	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 accorda 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 and O The patient has experienced intolerable side effects fro	adalimumab and/or etanercept and/or secukinumab for psoriatic arthritis
or Following 3-4 months' initial treatment with adalimuma renewal criteria for adalimumab and/or etanercept and,	b 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 accorda Hospital.	nce with a protocol or guideline that has been endorsed by the Health NZ
or clinically significant response to treatment in the opinio	provement in active joint count from baseline and a clinically significant
and O Infliximab to be administered at doses no greater than 5 mg/l	kg every 8 weeks

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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:		
Infliximab - continued			

	and	Ο	The patient has had an initial Special Authority approval for adalimumab for severe ocular inflammation
			O 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 severe ocular inflammation
r	\square		
	(and	Ο	Patient has severe, vision-threatening ocular inflammation requiring rapid control
			O Treatment with high-dose steroids (intravenous methylprednisolone) followed by high dose oral steroids has proven ineffective at controlling symptoms
		or	O Patient developed new inflammatory symptoms while receiving high dose steroids

	Ο	The patient has had a good clinical response following 3 initial doses
or	0	Following each 12-month treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria $\langle \frac{1}{2}$ + anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema)
or	0	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

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.

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:	Name:		
Ward:	NHI:		
Infliximab - continued			
INITIATION – chronic ocular inflammation Re-assessment required after 4 months			

	and	С	The	patient has had an initial Special Authority approval for adalimumab for chronic ocular inflammation
			Ο	The patient has experienced intolerable side effects from adalimumab
		or	0	The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for chronic ocular inflammation
or				
	and	С	Patie loss	ent has severe uveitis uncontrolled with treatment of steroids and other immunosuppressants with a severe risk of vision
			0	Patient is 18 years or older and treatment with at least two other immunomodulatory agents has proven ineffective
		or	Ο	Patient is under 18 years and treatment with methotrexate has proven ineffective or is not tolerated at therapeutic dose
		or	Ο	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

CONTINUATION – chronic ocular inflammation

Re-assessment required after 12 months

Prerequisites (t	tick boxes where	appropriate)
------------------	------------------	--------------

		0	The patient has had a good clinical response following 3 initial doses
	or or	0	Following each 12-month treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria $< \frac{1}{2}$ + anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema)
	0.	0	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
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.			
INITIATION – Pulmonary sarcoidosis Prerequisites (tick boxes where appropriate)			
	O Patient has life-threatening pulmonary sarcoidosis that is refractory to other treatments		

O Treatment is to be prescribed by, or has been recommended by, a physician with expertise in the treatment of pulmonary sarcoidosis

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

Re-a	sses	smen	Crohn's disease (adults) t required after 6 months (tick boxes where appropriate)		
(and		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.			
	and	0	Patient has 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	O 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		
	and		O Patient has an ileostomy or colostomy, and has intestinal inflammation		
		0	Patient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators and corticosteroids		
Re-a	sses	smen	DN – Crohn's disease (adults) t required after 2 years (tick boxes where appropriate)		
(and			cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.		
		or	O 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		
		or	O CDAI score is 150 or less, or HBI is 4 or less		
	and		O The patient has demonstrated an adequate response to treatment but CDAI score and/or HBI score cannot be assessed		
		0	Infliximab 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 up to 3 doses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen weeks after completing the last re-induction cycle		
			Crohn's disease (children)		
			t required after 6 months (tick boxes where appropriate)		
(and			cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.		
	and	0	Paediatric patient has active Crohn's disease		
		or	O Patient has a PCDAI score of greater than or equal to 30		
			O Patient has extensive small intestine disease		
	and	0	Patient has tried but experienced an inadequate response to, or intolerable side effects from, prior therapy with immunomodulators and corticosteroids		

Signed: Date:

Use this checklist to determine if a patient meets the restrictions for funding in th Schedule. For community funding, see the Special Authority Criteria.	e hospital setting . For more details, refer to Section H of the Pharmaceutical
DECODED	DATIENT

PRESCH	RIBER		PATIENT:
Name:			
Ward:			NHI:
Inflixin	nab -	contin	ued
Re-asse	essmer	nt requ	Crohn's disease (children) nired after 2 years poxes where appropriate)
and	Pres		by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
		0	PCDAI score has reduced by 10 points from the PCDAI score when the patient was initiated on infliximab
	or	Ο	PCDAI score is 15 or less
		Ο	The patient has demonstrated an adequate response to treatment but PCDAI score cannot be assessed
a	nd	up to	imab 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 as after completing the last re-induction cycle
Prereque O		cribed bital.	boxes where appropriate) by, or recommended by a gastroenterologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
a	nd		ant has confirmed Crohn's disease
	or	\bigcirc	Patient has one or more complex externally draining enterocutaneous fistula(e)
	or	\bigcirc	Patient has one or more rectovaginal fistula(e) Patient has complete peri-anal fistula
Re-asse Prerequ	essmer uisites Pres	nt requ (tick b	istulising Crohn's disease ired 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 Health al.
and		0	The number of open draining fistulae have decreased from baseline by at least 50%
	or	0	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
a	nd	up to	imab 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 as after completing the last re-induction cycle

	checklist to determine if a patient meets the restrictions for funding in the For community funding, see the Special Authority Criteria.	the hospital setting . For more details, refer to Section H of the Pharmaceutical
PRESCF	RIBER	PATIENT
Name: .		Name:
Ward:		NHI:
Inflixim	nab - continued	
	ION – acute fulminant ulcerative colitis essment required after 6 weeks	
	uisites (tick boxes where appropriate)	
and	Prescribed by, or recommended by a gastroenterologist, or in accord Hospital.	rdance with a protocol or guideline that has been endorsed by the Health NZ
ar	\bigcirc Patient has acute, fulminant ulcerative colitis	
	O Treatment with intravenous or high dose oral corticosteroids	has not been successful
and	NZ Hospital. O Where maintenance treatment is considered appropriate, infl reassessed every 6 months Infliximab to be administered at doses up to 5 mg/kg every 8	ccordance with a protocol or guideline that has been endorsed by the Health iximab should be used in combination with immunomodulators and weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for ment for re-induction. Another re-induction may be considered sixteen
Re-asse Prerequ and ard	NZ Hospital. Patient has active ulcerative colitis nd O Patients SCCAI is greater than or equal to 4 or O Patients PUCAI score is greater than or equal to 20	ccordance with a protocol or guideline that has been endorsed by the Health
ar	nd O Patient has experienced an inadequate response to, or intole	rable side effects from, prior therapy with immunomodulators and

systemic corticosteroids

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	CRI	BER			PATIENT:
Name	:				Name:
Ward:					NHI:
Inflix	ima	ab -	contin	nued	
Re-a	sses	smer	nt requ	uired a	tive colitis fter 2 years
Prere	equi	sites	(tick t	ooxes	where appropriate)
and			cribed lospita		r recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
		or	0	The	SCCAI score has reduced by 2 points or more from the SCCAI score when the patient was initiated on infliximab
			0	The	PUCAI score has reduced by 30 points or more from the PUCAI score when the patient was initiated on infliximab
	and	O	up to	3 do	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 ses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen or completing the last re-induction cycle
Re-a	sses equi	smer sites	nt requ (tick t cribed	uired a poxes	riasis Ifter 3 doses where appropriate) r recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
	or	ar	O Id or	psor	ent has had an initial Special Authority approval for adalimumab, etanercept or secukinumab for severe chronic plaque iasis 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
Noto		ar ar ar		Patie of th A PA cour The	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 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 ent has 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 NSI 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, sever	still han re, a	on tr d, foo nd fo	eatme ot, gen r the fa	nt but iital or ace, p	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.

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:	Name:		
Ward:	NHI:		

Infliximab - continued

	and	О	Patient had "whole body" severe chronic plaque psoriasis at the start of treatment Following each prior infliximab 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-infliximab treatment baseline value
or	and	С	Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment
		or	 Following each prior infliximab 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 infliximab 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-infliximab treatment baseline value
or	and	О	Patient 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 O Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQ prior to commencing infliximab

INITIATION – neurosarcoidosis Re-assessment required after 18 months									
Prerequisites (tick boxes where appropriate)									
O Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Heat Hospital.									
(and	С	Biopsy consistent with diagnosis of neurosarcoidosis							
(С	Patient has CNS involvement							
and (С	Patient has steroid-refractory disease							
and	_								
		O IV cyclophosphamide has been tried							
	or	O Treatment with IV cyclophosphamide is clinically inappropriate							
	assess requisi F H (and (and (and	assessmen requisites Presc Hosp and and and and							

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	
and Hospital.	e with a protocol or guideline that has been endorsed by the Health NZ
or A withdrawal period has been tried and the patient has relap or A withdrawal period has been considered but would ne and There has been a marked reduction in prednisone dos and O There has been an improvement in MRI appear. or O Marked improvement in other symptomology	ot be clinically appropriate
INITIATION – severe Behcet's disease Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	tly impacting the patient's quality of life (see Notes) sculitic symptoms and has not responded adequately to one or more
or	(see Notes)
and O The patient is experiencing significant loss of quality of life	
	ed in Gilworth et al J Rheumatol. 2004;31:931-7. onsidered standard conventional treatments for these symptoms, for example otoms; azathioprine, steroids, thalidomide, interferon alpha and ciclosporin for
CONTINUATION – severe Behcet's disease Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Patient has had a good clinical response to initial treatment and	with measurably improved quality of life

O Infliximab to be administered at doses no greater than 5 mg/kg every 8 weeks

I confirm that the above details are correct:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Infliximab - continued	
INITIATION – pyoderma gangrenosum Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a dermatologist, or in accordance Hospital. and	e with a protocol or guideline that has been endorsed by the Health NZ
azathioprine, or methotrexate) and not received an adequate re and O 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) O 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	
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

PRES	SCRIE	BER		PATIENT:						
Name	e:			Name:						
Ward	:			NHI:						
Inflix	kima	b - d	continued							
			nflammatory bowel arthritis (peripheral) t required after 6 months							
			(tick boxes where appropriate)							
	and	Ο	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,						
		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						
	and	0	Patient has tried and not experienced a response to at least three months of sulfasalazine at a maximum tolerated dose (unless contraindicated)							
	and		O Potient has a CPP lovel greater than 15 mg/l measures	I no more than one month prior to the date of this application						
		or	0							
		or	• Patient has an ESR greater than 25 mm per hour measure	ured no more than one month prior to the date of this application						
			O ESR and CRP not measured as patient is currently rece has done so for more than three months	iving prednisone therapy at a dose of greater than 5 mg per day and						
\square										
			ON – Inflammatory bowel arthritis (peripheral) It 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						
		0	Patient has experienced at least a continuing 30% improvement physician	nt in active joint count from baseline in the opinion of the treating						
\square										

RS2067 - Tocilizumab

Rheumatoid Arthritis - INITIATION	334
Rheumatoid Arthritis - CONTINUATION	
Rheumatoid Arthritis (patients previously treated with adalimumab or etanercept) - INITIATION	
Adult-onset Still's disease - INITIATION	
Adult-onset Still's disease - CONTINUATION	
Cytokine release syndrome - INITIATION	332
Idiopathic multicentric Castleman's disease - INITIATION	
Idiopathic multicentric Castleman's disease - CONTINUATION	
Moderate to severe COVID-19 - INITIATION	
Polyarticular juvenile idiopathic arthritis - INITIATION	
Polyarticular juvenile idiopathic arthritis - CONTINUATION	
Previous use - INITIATION	332
Systemic juvenile idiopathic arthritis - INITIATION	334
Systemic juvenile idiopathic arthritis - CONTINUATION	

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:

Tocilizumab

Re-a	ssess	ment rec	tine release syndrome uired after 3 doses boxes where appropriate)
	(and	The patient has developed grade 3 or 4 cytokine release syndrome associated with the administration of blinatumomab for the treatment of acute lymphoblastic leukaemia Tocilizumab is to be administered at doses no greater than 8 mg/kg IV for a maximum of 3 doses (if less than 30kg, maximum of 12 mg/kg)
	or	and and	The patient is enrolled in the Malaghan Institute of Medical Research ENABLE trial programme The patient has developed CRS or Immune Effector Cell-Associated Neurotoxicity Syndrome (ICANS) following CAR T-Cell therapy for the treatment of relapsed or refractory B-cell non-Hodgkin lymphoma Tocilizumab is to be administered according to the consensus guidelines for CRS or ICANS for CAR T-cell therapy at doses no greater than 8 mg/kg IV for a maximum of 3 doses
Re-a	ssess	ment rec	ous use uired after 6 months boxes where appropriate)
(and		Prescribe NZ Hospi	d by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health al.
	and	O Pat	ent was being treated with tocilizumab prior to 1 February 2019
		or C	Rheumatoid arthritis Systemic juvenile idiopathic arthritis
		or or	Adult-onset Still's disease
		or	Polyarticular juvenile idiopathic arthritis
			Idiopathic multicentric Castleman's disease

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							PA	ITIENT:		
Name	e:								Nar	ime:		
Ward	:								NH	11:		
Toci	lizun	nab	- con	tinued	d							
						ritis (patients months	s previously t	reated with adal	limur	mab or etanercept)		
						appropriate)						
(and		Prescribed by, or recommended by a rheumatologist or Pract protocol or guideline that has been endorsed by the Health N						ioner on the recommendation of a rheumatologist, or in accordance with a Hospital.				
O The patient has had an initial Special Authority approval for adalimumab and/or etanercept for rheumatoid an and						numab and/or etanercept for rheumatoid arthritis						
			Ο	The p	oatien	t has experien	ced intolerable	e side effects fror	m ada	alimumab and/or etanercept		
		or	r O 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									
	and										$\neg \parallel$	
		or	\bigcirc	The	oatien	t is seronegati	ve for both ant	ti-cyclic citrullinat	ted pe	peptide (CCP) antibodies and rheumatoid factor		
			and		The	patient has be	en started on	rituximab for rheu	umat	toid arthritis in a Health NZ Hospital		
					or	Ο	The patient h	nas experience	ed intolerable side	le effe	ects from rituximab	
					Ο			e initial course of iteria for rheumat		ximab the patient has received insufficient benefit such that they arthritis		

PRES	PRESCRIBER			PATIENT:
Name	Name:			
Ward	Nard:			NHI:
Тосі	lizum	nab	- <i>co</i> i	ntinued
		t requ (tick k cribed	ired after 6 months	
and	(and	C C	Patie citrul	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 izumab is to be used as monotherapy
	and	or	0 0	Treatment with methotrexate is contraindicated Patient has tried and did not tolerate oral and/or parenteral methotrexate
	and	or	0 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 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 0	Patient has persistent symptoms of poorly controlled and active disease in at least 20 active, swollen, tender joints 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 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 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
INITIATION – systemic juvenile idiopathic arthritis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)		ired after 6 months poxes where appropriate)		
and			col or Patie Patie	by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.

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:			Name:	
Ward: NHI:				NHI:
Tocil	izun	nab -	con	inued
Re-a	ssess equis C F	sment i s ites (ti Prescri	requi ck b bed	nset Still's disease red 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 guideline that has been endorsed by the Health NZ Hospital.
		and	or	(AOSD) O The patient has been started on tocilizumab for AOSD in a Health NZ Hospital
	or		or	 O The patient has experienced intolerable side effects from adalimumab and/or etanercept O 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 (and	С С С	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 antiinflammatory drugs (NSAIDs) and methotrexate Patient has persistent symptoms of disabling poorly controlled and active disease
Re-a	ssess equis F	sment i s ites (ti Prescri	equi ck b bed	icular juvenile idiopathic arthritis red after 4 months oxes where appropriate) oy, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a puideline that has been endorsed by the Health NZ Hospital.
	or	and		The patient has had an initial Special Authority approval for both etanercept and adalimumab for polyarticular course juvenile idiopathic arthritis (JIA) The patient has experienced intolerable side effects, or has received insufficient benefit from, both etanercept and adalimumab
	or	and (and (and	C C C Or Or	 Treatment with a tumour necrosis factor alpha inhibitor is contraindicated Patient has had polyarticular course JIA for 6 months duration or longer To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance 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) Moderate or high disease activity (cJADAS10 score of at least 2.5) after a 3-month trial of methotrexate (at the maximum tolerated dose) Low disease activity (cJADAS10 score between 1.1 and 2.5) after a 6-month trial of methotrexate

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:
Tocilizumab - continued	
INITIATION – idiopathic multicentric Castleman's disease Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a haematologist, rheumatologis or in accordance with a protocol or guideline that has been endorse and O Patient has severe HHV-8 negative idiopathic multicentric Ca	
Treatment with an adequate trial of corticosteroids has proven and Tocilizumab to be administered at doses no greater than 8 mg	
INITIATION – moderate to severe COVID-19 Re-assessment required after 1 dose Prerequisites (tick boxes where appropriate)	
 Patient has confirmed (or probable) COVID-19 and Oxygen saturation of < 92% on room air, or requiring supplen and Patient is receiving adjunct systemic corticosteroids, or system and Tocilizumab is to be administered at doses no greater than 8r and Tocilizumab is not to be administered in combination with bar 	nic corticosteroids are contraindicated ng/kg IV for a maximum of one dose
CONTINUATION – Rheumatoid Arthritis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a rheumatologist or Practitioner protocol or guideline that has been endorsed by the Health NZ Hos	on the recommendation of a rheumatologist, or in accordance with a pital.
or significant response to treatment in the opinion of the physicia	ast a continuing 30% improvement in active joint count from baseline and
CONTINUATION – systemic juvenile idiopathic arthritis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a rheumatologist or Practitioner protocol or guideline that has been endorsed by the Health NZ Hos	on the recommendation of a rheumatologist, or in accordance with a pital.
and Following up to 6 months' initial treatment, the patient has ac improvement criteria (ACR Pedi 30) response from baseline O On subsequent reapplications, the patient demonstrates at le	hieved at least an American College of Rheumatology paediatric 30% ast a continuing ACR Pedi 30 response from baseline

I confirm that the above details are correct:

and

March 202			RESTRICTIONS CHECKLIST	Page 33
		letermine if a patient meets the restric unity funding, see the Special Authori	tions for funding in the hospital setting . For more details, refer to a ty Criteria.	Section H of the Pharmaceutical
PRESCRII	BER		PATIENT:	
Name:			Name:	
Ward:			NHI:	
Tocilizui	mab - col	ntinued		
Re-asses	sment requ	adult-onset Still's disease uired after 6 months box where appropriate)		
and	Prescribed protocol or	d by, or recommended by a rheumatol guideline that has been endorsed by	ogist or Practitioner on the recommendation of a rheumatologist, o the Health NZ Hospital. ammatory markers and functional status	r in accordance with a
Re-asses Prerequis	sment requ sites (tick b Prescribed	polyarticular juvenile idiopathic art uired after 6 months boxes where appropriate) d by, or recommended by a rheumatol r guideline that has been endorsed by	logist or Practitioner on the recommendation of a rheumatologist, o	or in accordance with a
and	O Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance			
	or O	physician's global assessment from	patient demonstrates at least a continuing 30% improvement in act	
Re-asses Prerequis	sment requ sites (tick b	idiopathic multicentric Castleman's uired after 12 months box where appropriate) d by, or recommended by a haematolo	s disease ogist, rheumatologist or Practitioner on the recommendation of a ha	aematologist or rheumatologist.

or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. \bigcirc

The treatment remains appropriate and the patient has a sustained improvement in inflammatory markers and functional status

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:	Name:
Ward:	NHI:
Omalizumab	

Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a clinical immunologist or respiratory specialist, or in accordance with a protocol or guideline that has been			
and O A A A A A A A A A A A A A A A A A A	Patient must be aged 6 years or older 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 testing or RAST Total serum human immunoglobulin E (IgE) between 76 IU/mL and 1300 IU/ml at baseline Proven adherence with optimal inhaled therapy including high dose inhaled corticosteroid (budesonide 1,600 mcg per day or fluticasone propionate 1,000 mcg per day or equivalent), plus long-acting beta-2 agonist therapy (at least salmeterol 50 mcg bd or		
and	eformoterol 12 mcg bd) for at least 12 months, unless contraindicated or not tolerated O Patient has received courses of systemic corticosteroids equivalent to at least 28 days treatment in the past 12 months, unless contraindicated or not tolerated		
and 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 26 weeks after the first dose to assess response to treatment		
Re-assessme	ON – severe asthma nt required after 6 months s (tick boxes where appropriate)		

O Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

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

A reduction in the maintenance oral corticosteroid dose or number of exacerbations of at least 50% from baseline

 \bigcirc

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:		Name:
Ward:		NHI:
Omalizu	mab - continued	
Re-assess Prerequis	N – severe chronic spontaneous urticaria sment required after 6 months ites (tick boxes where appropriate) Prescribed by, or recommended by a clinical immunologist or dermendorsed by the Health NZ Hospital.	natologist, or in accordance with a protocol or guideline that has been
and	O Patient must be aged 12 years or older	
	O Patient is symptomatic with Urticaria Activity Sco and O Patient has a Dermatology life quality index (DLC	
and		
	or 6 weeks	
and	O Treatment to be stopped if inadequate response* follow	wing 4 doses
	or O Complete response* to 6 doses of omalizumab	
		(رئ
Re-assess Prerequis	ATION – severe chronic spontaneous urticaria sment required after 6 months sites (tick boxes where appropriate) Prescribed by, or recommended by a clinical immunologist or dermendorsed by the Health NZ Hospital.	natologist, or in accordance with a protocol or guideline that has been
and	O Patient has previously had a complete response* to 6 doses	of omalizumab
	O Patient has previously had a complete response* to 6 and O Patient has relapsed after cessation of omalizumab the	

Note: *Inadequate response defined as less than 50% reduction in baseline UAS7 and DLQI score, or an increase in Urticaria Control Test (UCT) score of less than 4 from baseline. Patient is to be reassessed for response after 4 doses of omalizumab. Complete response is defined as UAS7 less than or equal to 6 and DLQI less than or equal to 5; or UCT of 16. Relapse of chronic urticaria on stopping prednisone/ciclosporin does not justify the funding of omalizumab.

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:

Siltuximab

and

INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)				
and	Prescribed by, or recommended by a haematologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed the Health NZ Hospital.	у		
and	 Patient has severe HHV-8 negative idiopathic multicentric Castleman's Disease Treatment with an adequate trial of corticosteroids has proven ineffective Siltuximab is to be administered at doses no greater than 11 mg/kg every 3 weeks 			
Re-a	NUATION essment required after 12 months uisites (tick box where appropriate) Prescribed by, or recommended by a haematologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by			

the Health NZ Hospital.

The treatment remains appropriate and the patient has sustained improvement in inflammatory markers and functional status

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:		
Obinutuzumab			

INITIATION Re-assessment required after 6 months				
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.				
 The patient has progressive Binet stage A, B or C CD20+ chronic lymphocytic leukaemia requiring treatment and The patient is obinutuzumab treatment naive and 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 Obinutuzumab to be administered at a maximum cumulative dose of 8,000 mg and in combination with chlorambucil for a maximum of 6 cycles Note: Chronic lymphocytic leukaemia includes small lymphocytic lymphoma. Comorbidity refers only to illness/impairment other than CLL induced 				
illness/impairment in the patient. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL disease symptoms a higher ECOG (2 or 3) is acceptable where treatment with obinutuzumab is expected to improve symptoms and improve ECOG score to < 2. * greater than or equal to 1.5×10^{9} /L and platelets greater than or equal to 75×10^{9} /L				
INITIATION – follicular / marginal zone lymphoma Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)				
or O Patient has follicular lymphoma O Patient has marginal zone lymphoma				
 and Patient is refractory to or has relapsed within 12 months of a rituximab containing combined chemo-immunotherapy regimen* and Patient has an ECOG performance status of 0-2 and Patient has been previously treated with no more than four chemotherapy regimens and Obinutuzumab to be administered at a maximum dose of 1000 mg for a maximum of 6 cycles in combination with chemotherapy* 				
Note: * includes unapproved indications				
CONTINUATION – follicular / marginal zone lymphoma				

Re-assessment required after 24 months **Prerequisites** (tick boxes where appropriate)

O Patient has no evidence of disease progression following obinutuzumab induction therapy

and Obinutuzumab to be administered at a maximum of 1000 mg every 2 months for a maximum of 2 years and

O Obinutuzumab to be discontinued at disease progression

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:	Name:		
Ward:	NHI:		
Pertuzumab			

	smen	t required after 12 months (tick boxes where appropriate)
and	0	The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)
	or	O Patient is chemotherapy treatment naive
		O 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	0	The patient has good performance status (ECOG grade 0-1)
and	0	Pertuzumab to be administered in combination with trastuzumab
and	0	Pertuzumab maximum first dose of 840 mg, followed by maximum of 420 mg every 3 weeks
	\bigcirc	Pertuzumab to be discontinued at disease progression
	smen	N t required after 12 months (tick boxes where appropriate)
	and	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 pertuzumab and trastuzumab
or	and	O Patient has previously discontinued treatment with pertuzumab and trastuzumab for reasons other than severe toxicity or disease progression
	and	 Patient has signs of disease progression Disease has not progressed during previous treatment with pertuzumab and trastuzumab

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:	Name:	
Ward:	NHI:	

Cetuximab

and

and

or

INITIATION – head and neck cancer, locally advanced			
Prerequisites (tick boxes where appropriate)			
O Patient has locally advanced, non-metastatic, squamous cell cancer of the head and neck			
Cisplatin is contraindicated or has resulted in intolerable side effects and			
O Patient has an ECOG performance score of 0-2			
O To be administered in combination with radiation therapy			
INITIATION – colorectal cancer, metastatic Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)			
O Patient has metastatic colorectal cancer located on the left side of the colon (see Note)			
and O There is documentation confirming disease is RAS and BRAF wild-type			
And O Patient has an ECOG performance score of 0-2			

O Cetuximab is to be used in combination with chemotherapy

Patient has not received prior funded treatment with cetuximab

 $m O\,$ Chemotherapy is determined to not be in the best interest of the patient based on clinician assessment

CONTINUATION – colorectal cancer, metastatic Re-assessment required after 6 months Prerequisites (tick box where appropriate)

O No evidence of disease progression

Note: Left-sided colorectal cancer comprises of the distal one-third of the transverse colon, the splenic flexure, the descending colon, the sigmoid colon, or the rectum.

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.

RESCRI	BER		PATIENT:	
lame:			Name:	
Vard:				
fliberce	ept			
Re-assess Prerequis	sment sites (t Prescri	requ ick b ibed	Age Related Macular Degeneration uired after 3 months boxes where appropriate) d by, or recommended by an ophthalmologist or nurse practitioner, or in accorr by the Health NZ Hospital.	rdance with a protocol or guideline that has been
and	endors			
		or or	O Polypoidal choroidal vasculopathy	
	and			
		or	 O The patient has developed severe endophthalmitis or severe posterio r O There is worsening of vision or failure of retina to dry despite three intapart 	
	and and	0	There is no structural damage to the central fovea of the treated eye Patient has not previously been treated with ranibizumab for longer than 3 r	months
or	or	0	Patient has current approval to use ranibizumab for treatment of wAMD and 3 months	d was found to be intolerant to ranibizumab within
		0	Patient has previously* (*before June 2018) received treatment with ranibize treatment	umab for wAMD and disease was stable while on
Re-assess Prerequis	sment sites (t Prescri	requ ick b ibed	Wet Age Related Macular Degeneration uired after 12 months boxes where appropriate) d by, or recommended by an ophthalmologist or nurse practitioner, or in accorr by the Health NZ Hospital.	rdance with a protocol or guideline that has been

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:

and

 \bigcirc

and

and

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:
Aflibercept - continued	
INITIATION – Diabetic Macular Oedema Re-assessment required after 4 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by an ophthalmologist or nurse praendorsed by the Health NZ Hospital. and	ctitioner, or in accordance with a protocol or guideline that has been
 Patient has centre involving diabetic macular oedema (DMO) and Patient's disease is non responsive to 4 doses of intravitreal to and Patient has reduced visual acuity between 6/9 – 6/36 with fundand Patient has DMO within central OCT (ocular coherence tomogrand There is no centre-involving sub-retinal fibrosis or foveal atrop 	ctional awareness of reduction in vision graphy) subfield > 350 micrometers
and endorsed by the Health NZ Hospital. There is stability or two lines of Snellen visual acuity gain and There is structural improvement on OCT scan (with reduction and Patient's vision is 6/36 or better on the Snellen visual acuity s and There is no centre-involving sub-retinal fibrosis or foveal atrop and	shy
After each consecutive 12 months treatment with aflibercept, no response	patient has retrialled with at least one injection of bevacizumab and had

I confirm that the above details are correct:

PRES	SCRIE	BER	PATIENT:
Name	e:		Name:
Ward	:		NHI:
Secu	ukinu	uma	lb
Re-a	issess	smen	evere chronic plaque psoriasis, second-line biologic t required after 4 months (tick boxes where appropriate)
O Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Hospital.			
			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
		or	 O The patient has experienced intolerable side effects from adalimumab, etanercept or infliximab O The patient has received insufficient benefit from adalimumab, etanercept or infliximab
	and	0	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	issess equis	smen sites	PN – severe chronic plaque psoriasis, second-line biologic t required after 6 months (tick boxes where appropriate)
and	Prescribed by, or recommended by a dermatologist, or in accordance Hospital.		pribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.
		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
	and	Ō	Secukinumab to be administered at a maximum dose of 300 mg monthly

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	ER PA	TIENT:
Name:	Na	ame:
Ward:	Nł	
Secukinur	mab - continued	
INITIATION Re-assessm Prerequisite O Pri- Hc and	 severe chronic plaque psoriasis, first-line biologic nent required after 4 months tes (tick boxes where appropriate) rescribed by, or recommended by a dermatologist, or in accordance w ospital. Patient has "whole body" severe chronic plaque psoriasis w 10, where lesions have been present for at least 6 months f Patient has severe chronic plaque psoriasis of the face, or p been present for at least 6 months from the time of initial di or Patient has severe chronic localised genital or flexural plaqu least 6 months from the time of initial diagnosis, and with a Patient has tried, but had an inadequate response (see Note) to, following (at maximum tolerated doses unless contraindicated): p A PASI assessment or Dermatology Quality of Life Index (DLQI) a 	ith a Psoriasis Area and Severity Index (PASI) score of greater than rom the time of initial diagnosis palm of a hand or sole of a foot, where the plaque or plaques have agnosis ue psoriasis where the plaques or lesions have been present for at Dermatology Life Quality Index (DLQI) score greater than 10 or has experienced intolerable side effects from, at least three of the hototherapy, methotrexate, ciclosporin, or acitretin assessment has been completed for at least the most recent prior
psoriasis, a recent prior for erythema more of the	The most recent PASI or DQLI assessment is no more than 1 mo atment course is defined as a minimum of 12 weeks of treatment. "Ina PASI score of greater than 10, as assessed preferably while still on tr treatment; for severe chronic plaque psoriasis of the face, hand, foot, a, thickness and scaling are rated as severe or very severe, and for the	than 1 month following cessation of each prior treatment course nth old at the time of application adequate response" is defined as: for whole body severe chronic plaque
Re-assessm Prerequisite	or secukinumab	ASI 75) as compared to baseline PASI prior to commencing I) improvement of 5 or more, as compared to baseline DLQI prior
and	and O The patient has experienced a reduction of 75% compared to the pre-treatment baseline value	6 or more in the skin area affected, or sustained at this level, as (DLQI) improvement of 5 or more, as compared to baseline DLQI

and

and

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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.

PRES	CRIBER	PATIENT:
Name	:	Name:
Ward		NHI:
Secu	kinumab - continued	
	ATION – ankylosing spondylitis, second-line biologic ssessment required after 3 months	
Prer	equisites (tick boxes where appropriate)	
(and	Prescribed by, or recommended by a rheumatologist, or in accordan Hospital.	ce with a protocol or guideline that has been endorsed by the Health NZ
	O The patient has had an initial Special Authority approval for ac and	alimumab and/or etanercept for ankylosing spondylitis
	O The patient has experienced intolerable side effects from or	n a reasonable trial of adalimumab and/or etanercept
		eatment, the patient did not meet the renewal criteria for adalimumab
\subseteq		
	TINUATION – ankylosing spondylitis, second-line biologic ssessment required after 6 months	
Prer	equisites (tick boxes where appropriate)	
(Prescribed by, or recommended by a rheumatologist, or in accordan Hospital.	ce with a protocol or guideline that has been endorsed by the Health NZ

\mathbf{O}	Following 12 weeks initial treatment of secukinumab treatment, BASDAI has improved by 4 or more points from pre-secukinumab
	baseline on a 10 point scale, or by 50%, whichever is less
and	

Physician considers that the patient has benefitted from treatment and that continued treatment is appropriate

Secukinumab to be administered at doses no greater than 150 mg monthly

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	IBER		PATIENT:
Name:			Name:
Ward: NHI:			NHI:
Secukin	numa	b - c	ontinued
Re-asses Prerequi	isites (requ tick b ribed	tic arthritis 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
	and	O I or	 Patient has had an initial Special Authority approval for adalimumab, etanercept or infliximab for psoriatic arthritis Patient has experienced intolerable side effects from adalimumab, etanercept or infliximab Patient has received insufficient benefit from adalimumab, etanercept or infliximab to meet the renewal criteria for adalimumab, etanercept or infliximab for psoriatic arthritis
or	and		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) O Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen, tender joints O Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist,
	and	l or or	 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
Re-asses	ssment	requ	soriatic arthritis red after 6 months oxes where appropriate)

O Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline Hospital.				by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
		0	0	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 secukinumab treatment in the opinion of the treating physician
	an	d	Sec	ukinumab to be administered at doses no greater than 300 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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:

Trastuzumab emtansine

Ο	Patient has early breast cancer expressing HER2 IHC3+ or ISH+
and O	Documentation of pathological invasive residual disease in the breast and/or axiliary lymph nodes following completion of surgery
and O	Patient has completed systemic neoadjuvant therapy with trastuzumab and chemotherapy prior to surgery
and O	Disease has not progressed during neoadjuvant therapy
and O	Patient has left ventricular ejection fraction of 45% or greater
	Adjuvant treatment with trastuzumab emtansine to be commenced within 12 weeks of surgery
and O	Trastuzumab emtansine to be discontinued at disease progression
	Total adjuvant treatment duration must not exceed 42 weeks (14 cycles)

Re-assessment required after 6 months **Prerequisites** (tick boxes where appropriate)

and	С	Patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)
and	С	Patient has previously received trastuzumab and chemotherapy, separately or in combination
	~	O The patient has received prior therapy for metastatic disease*
	or	O The patient developed disease recurrence during, or within six months of completing adjuvant therapy*
and (and	С	Patient has a good performance status (ECOG 0-1)
		O Patient does not have symptomatic brain metastases
	or	O Patient has brain metastases and has received prior local CNS therapy
and		
	or	O Patient has not received prior funded trastuzumab emtansine or trastuzumab deruxtecan treatment
		O Patient has discontinued trastuzumab deruxtecan due to intolerance and
		The cancer did not progress while on trastuzumab deruxtecan
and (С	Treatment to be discontinued at 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 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				
Treatment to be discontinued at disease progression				
Note: *Note: Prior or adjuvant therapy includes anthracycline, other chemotherapy, biological drugs, or endocrine therapy.				

I confirm that the above details are correct:

RS1973 - Rituximab

ABO-incompatible organ transplant - INITIATION	360
ANCA associated vasculitis - INITIATION	
ANCA associated vasculitis - CONTINUATION	
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	355
Chronic lymphocytic leukaemia - CONTINUATION	356
Membranous nephropathy - INITIATION	366
Membranous nephropathy - CONTINUATION	366
Neuromyelitis Optica Spectrum Disorder (NMOSD) - INITIATION	362
Neuromyelitis Optica Spectrum Disorder (NMOSD) - CONTINUATION	362
Severe Refractory Myasthenia Gravis - INITIATION	363
Severe Refractory Myasthenia Gravis - CONTINUATION	363
Severe antisynthetase syndrome - INITIATION	363
Severe antisynthetase syndrome - CONTINUATION	364
Steroid dependent nephrotic syndrome (SDNS) or frequently relapsing nephrotic syndrome (FRNS) - INITI	ATION
361	
Steroid dependent nephrotic syndrome (SDNS) or frequently relapsing nephrotic syndrome (FRNS) - CONTI	NUATIO
361	
Steroid resistant nephrotic syndrome (SRNS) - INITIATION	361
Steroid resistant nephrotic syndrome (SRNS) - CONTINUATION	
Aggressive CD20 positive NHL - INITIATION	
Aggressive CD20 positive NHL - CONTINUATION	
Anti-NMDA receptor autoimmune encephalitis - INITIATION	
Anti-NMDA receptor autoimmune encephalitis - CONTINUATION	365
Desensitisation prior to transplant - INITIATION	
Graft versus host disease - INITIATION	
Haemophilia with inhibitors - INITIATION	
Haemophilia with inhibitors - CONTINUATION	353
Immune thrombocytopenic purpura (ITP) - INITIATION	
Immune thrombocytopenic purpura (ITP) - CONTINUATION	358
Immunoglobulin G4-related disease (IgG4-RD*) - INITIATION	368
Immunoglobulin G4-related disease (IgG4-RD*) - CONTINUATION	368
Indolent, low-grade lymphomas or hairy cell leukaemia* - INITIATION	354
Indolent, Iow-grade lymphomas or hairy cell leukaemia* - INITIATION Indolent, Iow-grade lymphomas or hairy cell leukaemia* - CONTINUATION	354
Pemiphigus* - INITIATION	367
Pemiphigus* - CONTINUATION	368
Post-transplant - INITIATION	353
Post-transplant - CONTINUATION	353
Pure red cell aplasia (PRCA) - INITIATION	359
Pure red cell aplasia (PRCA) - CONTINUATION	
Severe chronic inflammatory demyelinating polyneuropathy - INITIATION	364
Severe chronic inflammatory demyelinating polyneuropathy - CONTINUATION	364
Severe cold haemagglutinin disease (CHAD) - INITIATION	356
Severe cold haemacqlutinin disease (CHAD) - CONTINUATION	356
Thrombotic thrombocytopenic purpura (TTP) - INITIATION	358
Thrombotic thrombocytopenic purpura (TTP) - CONTINUATION	358
Treatment refractory systemic lupus erythematosus (SLE) - INITIATION	360
Treatment refractory systemic lupus erythematosus (SLE) - CONTINUATION	360
Warm autoimmune haemolytic anaemia (warm AIHA) - INITIATION	357
Warm autoimmune haemolytic anaemia (warm AIHA) - CONTINUATION	357

PRESCRIBER		PATIENT:		
Name:		Name:		
Ward:		NHI:		
Ritu	ximab (Riximyo)			
INITI Prero (and	ATION – haemophilia with inhibitors equisites (tick boxes where appropriate)			
and	2			
	ATION – post-transplant equisites (tick boxes where appropriate)	rder*		
Note	: Indications marked with * are unapproved indications.			
	CONTINUATION – post-transplant Prerequisites (tick boxes where appropriate)			
Note	O The patient has had a rituximab treatment-free interval of 12 m and O The patient has B-cell post-transplant lymphoproliferative diso and O To be used for no more than 6 treatment cycles : Indications marked with * are unapproved indications.			

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Rituximab (Riximyo) - continued		
INITIATION – indolent, low-grade lymphomas or hairy cell leukaemia Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)		
To be used for a maximum of 6 treatment cycles	leukaemia* with relapsed disease following prior chemotherapy	
or O The patient has indolent, low grade lymphoma or ha and O To be used for a maximum of 6 treatment cycles	iry cell leukaemia* requiring first-line systemic chemotherapy	
Note: 'Indolent, low-grade lymphomas' includes follicular, mantle, margina indication. 'Hairy cell leukaemia' also includes hairy cell leukaemia varian	al zone and lymphoplasmacytic/Waldenstrom macroglobulinaemia. *Unapproved t.	
CONTINUATION – indolent, low-grade lymphomas or hairy cell leuka Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	emia*	
 The patient has had a rituximab treatment-free interval of and The patient has indolent, low-grade NHL or hairy cell leuk and To be used for no more than 6 treatment cycles 	12 months or more aemia* with relapsed disease following prior chemotherapy	
Note: 'Indolent, low-grade lymphomas' includes follicular, mantle, marginal zone and lymphoplasmacytic/Waldenstrom macroglobulinaemia. *Unappro indication. 'Hairy cell leukaemia' also includes hairy cell leukaemia variant.		
INITIATION – aggressive CD20 positive NHL Prerequisites (tick boxes where appropriate)		
O The patient has treatment naive aggressive CD20 p and O To be used with a multi-agent chemotherapy regime and O To be used for a maximum of 8 treatment cycles		
or O The patient has aggressive CD20 positive NHL with and O To be used for a maximum of 6 treatment cycles Note: 'Aggressive CD20 positive NHL' includes large B-cell lymphoma and		

PRESCRIE	BER	PATIENT:
Name:		Name:
Ward:		
Rituxima	ab (F	Riximyo) - <i>continued</i>
		DN – aggressive CD20 positive NHL
Prerequis	sites	(tick boxes where appropriate)
and	0	The patient has had a rituximab treatment-free interval of 12 months or more
and	0	The patient has relapsed refractory/aggressive CD20 positive NHL
and	0	To be used with a multi-agent chemotherapy regimen given with curative intent
	Ο	To be used for a maximum of 4 treatment cycles
Note: 'Age	gress	sive CD20 positive NHL' includes large B-cell lymphoma and Burkitt's lymphoma/leukaemia.
Re-assess	smen	Chronic lymphocytic leukaemia ht required after 12 months (tick boxes where appropriate)
and	0	The patient has progressive Binet stage A, B or C chronic lymphocytic leukaemia (CLL) requiring treatment
	or	O The patient is rituximab treatment naive
		O The patient is chemotherapy treatment naive
		O The patient's disease has relapsed following no more than three prior lines of chemotherapy treatment and
		O The patient has had a treatment-free interval of 12 months or more if previously treated with fludarabine and cyclophosphamide chemotherapy
	or	O 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	Ο	The patient has good performance status
	or	O The patient does not have chromosome 17p deletion CLL
		O Rituximab treatment is to be used in combination with funded venetoclax for relapsed/refractory chronic lymphocytic leukaemia
and	0	Rituximab to be administered in combination with fludarabine and cyclophosphamide, bendamustine or venetoclax for a maximum of 6 treatment cycles
and	0	It is planned that the patient receives full dose fludarabine and cyclophosphamide (orally or dose equivalent intravenous administration), bendamustine or venetoclax
Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma. A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL disease symptoms a higher ECOG (2 or 3) is acceptable where treatment with rituximab is expected to improve symptoms and improve ECOG score to < 2.		

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	PATIENT:
Name	e:	Name:
Ward	:	
Ritu	xima	b (Riximyo) - <i>continued</i>
CON	TINU	ATION – Chronic lymphocytic leukaemia ment required after 12 months
		ites (tick boxes where appropriate)
		O 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
		O The patient has had an interval of 36 months or more since commencement of initial rituximab treatment and
		O The patient does not have chromosome 17p deletion CLL and
		O It is planned that the patient receives full dose fludarabine and cyclophosphamide (orally or dose equivalent intravenous administration) or bendamustin
	and	O Rituximab to be administered in combination with fludarabine and cyclophosphamide, bendamustine or venetoclax for a maximum of 6 treatment cycles
		onic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma. A line of chemotherapy treatment is considered to comprise a known nerapeutic chemotherapy regimen and supportive treatments.
		N – severe cold haemagglutinin disease (CHAD)
		ment required after 8 weeks ites (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		O Patient has cold haemagglutinin disease*
	and	O Patient has severe disease which is characterized by symptomatic anaemia, transfusion dependence or disabling circulatory symptoms
	and	O 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	: Indi	cations marked with * are unapproved indications.
Re-a	ssess	ATION – severe cold haemagglutinin disease (CHAD) ment required after 8 weeks ites (tick boxes where appropriate)
O Prescribed Hospital.		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	O Previous treatment with lower doses of rituximab (100 mg weekly for 4 weeks) have proven ineffective and treatment with higher doses (375 mg/m ² weekly for 4 weeks) is now planned
		O Patient was previously treated with rituximab for severe cold haemagglutinin disease*
		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 th	e hospital setting. For more details, refer to Section H of the Pharmaceutical
Schedule. For community funding, see the Special Authority Criteria.	
	DATIENT
PRESCRIBER	PATIENT:

Name:	Name:				
Ward:	Nard: NHI:				
Rituxima	b (Riximyo) - <i>continued</i>				
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 with a protocol or guideline that has been endorsed by the Health NZ lospital.				
and (Patient has warm autoimmune haemolytic anaemia* One of the following treatments has been ineffective: steroids (including if patient requires ongoing steroids at doses equivalent to > 5 mg prednisone daily), cytotoxic agents (e.g. cyclophosphamide monotherapy or in combination), intravenous immunoglobulin 				
(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: India	cations marked with * are unapproved indications.				
Re-assess	ATION – warm autoimmune haemolytic anaemia (warm AIHA) ment required after 8 weeks ites (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 lospital.				
or (Previous treatment with lower doses of rituximab (100 mg weekly for 4 weeks) have proven ineffective and treatment with higher doses (375 mg/m ² weekly for 4 weeks) is now planned				
	O Patient was previously treated with rituximab for warm autoimmune haemolytic anaemia*				
	An initial response lasting at least 12 months was demonstrated and O Patient now requires repeat treatment				
Note: Indic	cations marked with * are unapproved indications.				
Re-assess	N – immune thrombocytopenic purpura (ITP) ment required after 8 weeks ites (tick boxes where appropriate)				
Ор	Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ lospital.				
	O Patient has immune thrombocytopenic purpura* with a platelet count of less than or equal to 20,000 platelets per microlitre or				
and	O Patient has immune thrombocytopenic purpura* with a platelet count of 20,000 to 30,000 platelets per microlitre and significant mucocutaneous bleeding				
and	O Treatment with steroids and splenectomy have been ineffective				
	or O Treatment with steroids has been ineffective and splenectomy is an absolute contraindication or				
	O Other treatments including steroids have been ineffective and patient is being prepared for elective surgery (e.g. splenectomy)				
and (and O 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: Indic	cations marked with * are unapproved indications.				

I confirm that the above details are correct:

Signed: Date: .	
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PRES	CRIBI	ER PATIENT:		
Name:				
Ward:		NHI:		
Ritux	imal	D (Riximyo) - <i>continued</i>		
Re-as	sessr	TION – immune thrombocytopenic purpura (ITP) nent required after 8 weeks tes (tick boxes where appropriate)		
and		rescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ospital.		
	(or	Previous treatment with lower doses of rituximab (100 mg weekly for 4 weeks) have proven ineffective and treatment with higher doses (375 mg/m ² weekly for 4 weeks) is now planned		
		O Patient was previously treated with rituximab for immune thrombocytopenic purpura*		
		An initial response lasting at least 12 months was demonstrated and O Patient now requires repeat treatment		
Note:	Indic	ations marked with * are unapproved indications.		
Re-assessment required after 8 weeks 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				
	(and	D 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		
		O Patient has thrombotic thrombocytopenic purpura* and has experienced progression of clinical symptoms or persistent thrombocytopenia despite plasma exchange or		
		O Patient has acute idiopathic thrombotic thrombocytopenic purpura* with neurological or cardiovascular pathology		
Note:	Indic	ations marked with * are unapproved indications.		
Re-as	sessr	ATION – thrombotic thrombocytopenic purpura (TTP) ment required after 8 weeks tes (tick boxes where appropriate)		
and		rescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ospital.		
	and	 Patient was previously treated with rituximab for thrombotic thrombocytopenic purpura* An initial response lasting at least 12 months was demonstrated 		
	and (and	D Patient now requires repeat treatment		
	(D 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:	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:
Ritu	kimab	(Rixim	nyo) - continued	
Re-a Prer	ssessm equisite D Pr Ho D Pa	ent req es (tick escribe spital. tient ha	e red cell aplasia (PRCA) quired after 6 weeks a box where appropriate) ed by, or recommended by a haematologist, or in accordance as autoimmune pure red cell aplasia* associated with a der narked with * are unapproved indications.	e with a protocol or guideline that has been endorsed by the Health NZ nonstrable B-cell lymphoproliferative disorder
CONTINUATION – pure red cell aplasia (PRCA) 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 O Patient was previously treated with rituximab for pure red cell aplasia* associated with a demonstrable B-cell lymphoproliferative disorder and demonstrated an initial response lasting at least 12 months Note: Indications marked with * are unapproved indications.				
INITIATION – ANCA associated vasculitis Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate)				
	and		ient has been diagnosed with ANCA associated vasculitis* e total rituximab dose would not exceed the equivalent of 37	75 mg/m ² of body-surface area per week for a total of 4 weeks
		Or _	Induction therapy with daily oral or pulse intravenous cyo disease after at least 3 months	clophosphamide has failed to achieve significant improvement of
		or or	Patient has previously had a cumulative dose of cycloph cyclophosphamide would result in a cumulative dose > 1	osphamide > 15 g or a further repeat 3 month induction course of 5 g
		or O	Cyclophosphamide and methotrexate are contraindicate	d
		or _	Patient is a female of child-bearing potential	
		0	Patient has a previous history of haemorrhagic cystitis, u	urological malignancy or haematological malignancy
Note: Indications marked with * are unapproved indications.				
Re-a	ssessm	ent rec	ANCA associated vasculitis quired after 8 weeks boxes where appropriate)	
	and) Pati	ient has been diagnosed with ANCA associated vasculitis*	
	and) Pati	ient has previously responded to treatment with rituximab b	out is now experiencing an acute flare of vasculitis
	and) The	e total rituximab dose would not exceed the equivalent of 37	75 mg/m ² of body-surface area per week for a total of 4 weeks

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				
HITUXIMAD (Riximyo) - continued INITIATION - treatment refractory systemic lupus erythematosus (SLE) Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a rheumatologist or nephrologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O The patient has severe, immediately life- or organ-threatening SLE* and O The disease has proved refractory to treatment with steroids at a dose of at least 1 mg/kg and O The disease has relapsed following prior treatment for at least 6 months with maximal tolerated doses of azathioprine, mycophenolate mofetil and high dose cyclophosphamide, or cyclophosphamide is contraindicated and Maximum of four 1000 mg infusions of rituximab Note: Indications marked with * are unapproved indications. CONTINUATION - treatment refractory systemic lupus erythematosus (SLE) Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a rheumatologist or nephrologist, or in accordance with a protocol or guideline that has been endorsed by				
and The Health NZ Hospital. And O Patient's SLE* achieved at least a partial response to the prev and O The disease has subsequently relapsed and O Maximum of two 1000 mg infusions of rituximab Note: Indications marked with * are unapproved indications.	ious round of prior rituximab treatment			
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.				

	his checklist to determine if a patient meets the restrictions for funding i dule. For community funding, see the Special Authority Criteria.	in the hospital setting . For more details, refer to Section H of the Pharmaceutical
PRES	SCRIBER	PATIENT:
Name	2:	Name:
Ward	:	NHI:
Ritu	ximab (Riximyo) - continued	
Re-a	ATION – Steroid dependent nephrotic syndrome (SDNS) or frequessessment required after 8 weeks equisites (tick boxes where appropriate) O Prescribed by, or recommended by a nephrologist, or in accordan Hospital.	ently relapsing nephrotic syndrome (FRNS) nce with a protocol or guideline that has been endorsed by the Health NZ
	O Patient is a child with SDNS* or FRNS*	
	and O Treatment with steroids for at least a period of 3 months has been ineffective or associated with evidence of steroid toxicity	
and Treatment with ciclosporin for at least a period of 3 months has been ineffective and/or discontinued due to unaccept and Treatment with mycophenolate for at least a period of 3 months with no reduction in disease relapses and The total rituximab dose used would not exceed the equivalent of 375 mg/m ² of body surface area per week for a t		has been ineffective and/or discontinued due to unacceptable side effects
		onths with no reduction in disease relapses
		alent of 375 mg/m ² of body surface area per week for a total of 4 weeks
Note	: Indications marked with a * are unapproved indications.	
Re-a	ITINUATION – Steroid dependent nephrotic syndrome (SDNS) or flassessment required after 8 weeks equisites (tick boxes where appropriate) O Prescribed by, or recommended by a nephrologist, or in accordant Hospital.	nce with a protocol or guideline that has been endorsed by the Health NZ
	O Patient who was previously treated with rituximab for nephi	rotic syndrome*
	\sim	as demonstrated sustained response for > 6 months, but the condition has
	The total rituximab dose used would not exceed the equiva	alent of 375 mg/m ² of body surface area per week for a total of 4 weeks
Note	: Indications marked with a * are unapproved indications.	
Re-a		nce with a protocol or guideline that has been endorsed by the Health NZ
and	Hospital.	
	\bigcirc Patient is a child with SRNS* where treatment with steroids and	s and ciclosporin for at least 3 months have been ineffective
	O Treatment with tacrolimus for at least 3 months has been in and	neffective
O Genetic causes of nephrotic syndrome have been excluded and		d I
	$\hat{}$	alent of 375 mg/m ² of body surface area per week for a total of 4 weeks

Note: Indications marked with a * 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	SCRIBER	R PA	TIENT:
Name	e:	Na	me:
Ward	:		И:
Ritu	ximab ((Riximyo) - <i>continued</i>	
Re-a	issessme equisites	ION – Steroid resistant nephrotic syndrome (SRNS) ent required after 8 weeks s (tick boxes where appropriate)	a a protocol or guideling that has been endered by the Health NZ
and		scribed by, or recommended by a nephrologist, or in accordance with spital.	ra protocor or guideline that has been endorsed by the Health NZ
	and	Patient who was previously treated with rituximab for nephrotic sy	ndrome*
Treatment with rituximab was previously successful and has demonstrated sustained response for greater than 6 condition has relapsed and the patient now requires repeat treatment		ent	
		The total rituximab dose used would not exceed the equivalent of	375 mg/m ² of body surface area per week for a total of 4 weeks
Note	: Indicati	ions marked with a * are unapproved indications.	
		ent required after 6 months s (tick boxes where appropriate) One of the following dose regimens is to be used: 2 doses of 1,00 weekly for four weeks	0 mg rituximab administered fortnightly, or 4 doses of 375 mg/m2 administered
O The patient has experienced a severe episode or attack of NMOSD (rapidly progressing symptoms and clinical investiga supportive of a severe attack of NMOSD) or		MOSD (rapidly progressing symptoms and clinical investigations	
		O The patient has experienced a breakthrough attack of and O The patient is receiving treatment with mycophenolate and	
		O The patients is receiving treatment with corticosteroid	s
\square			
Re-a	issessme	ION – Neuromyelitis Optica Spectrum Disorder (NMOSD) ent required after 2 years s (tick boxes where appropriate)	
	O	One of the following dose regimens is to be used: 2 doses of 1,00 weekly for four weeks	0 mg rituximab administered fortnightly, or 4 doses of 375 mg/m2 administered
	and and	The patients has responded to the most recent course of rituximal	
	O The patient has not received rituximab in the previous 6 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.

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward: NHI:		
Rituximab (Riximyo) - continued		
INITIATION - Severe Refractory Myasthenia Gravis Re-assessment required after 2 years Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a neurologist, or in accordation Hospital. and O One of the following dose regimens is to be used: 375 m weekly for four weeks, or two 1,000 mg doses given two and O Treatment with corticosteroids and at least one oth ineffective O Treatment with at least one other immunosu	her immunosuppressant for at least a period of 12 months has been	
CONTINUATION – Severe Refractory Myasthenia Gravis Re-assessment required after 2 years Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O O 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		
or least 12 months O The patient's myasthenia gravis has relapse least 12 months	nstrated orticosteroids and at least one other immunosuppressant for a period of at ed despite treatment with at least one immunosuppressant for a period of at t 12 months and have been discontinued due to unacceptable side effects	
INITIATION – Severe antisynthetase syndrome Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Patient has confirmed antisynthetase syndrome and O Patient has confirmed antisynthetase syndrome and O Patient has confirmed antisynthetase syndrome and O Patient has severe, immediately life or organ threatening disease, including interstitial lung disease and O Treatment with at least 3 immunosuppressants (oral steroids, cyclophosphamide, methotrexate, mycophenolate, ciclosporin, azathioprine) has not be effective at controlling active disease or O Rapid treatment is required due to life threatening complications and		
O Maximum of four 1,000 mg infusions of rituximab		

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	R PATIENT:		
Name:	Name:		
Ward:	Vard: NHI:		
Rituximab ((Riximyo) - <i>continued</i>		
CONTINUATIO	TION – Severe antisynthetase syndrome		
	Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)		
Prerequisites	(lick boxes where appropriate)		
and	O Patient's disease has responded to the previous rituximab treatment with demonstrated improvement in inflammatory markers, muscle strength and pulmonary function		
O	O The patient has not received rituximab in the previous 6 months		
and	D Maximum of two cycles of 2 \times 1,000 mg infusions of rituximab given two we	eks apart	
INITIATION – graft versus host disease Prerequisites (tick boxes where appropriate)			
and	Patient has refractory graft versus host disease following transplant		
0	 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 		
	 Patient has severe chronic inflammatory demyelinating polyneuropathy (CIP Treatment with steroids and intravenous immunoglobulin and/or active disease At least one other immunosuppressant (cyclophosphamide, cicle effective at controlling active disease 	D) plasma exchange has not been effective at controlling	
or	or O Rapid treatment is required due to life threatening complications		
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	TION – severe chronic inflammatory demyelinating polyneuropathy nent required after 6 months es (tick boxes where appropriate)		
O	Patient's disease has responded to the previous rituximab treatment with de compared to baseline	monstrated improvement in neurological function	
and O and) The patient has not received rituximab in the previous 6 months		
0	One of the following dose regimens is to be used: 375 mg/m2 of body surfa weekly for four weeks, or two 1,000 mg doses given two weeks apart	ce area per week for a total of four weeks, or 500 mg once	
<			

	PATIENT:
ame:	Name:
'ard:	NHI:
ituximab (Riximyo) - continued	
NITIATION – anti-NMDA receptor autoimmune encephalitis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a neurologist, or in acc Hospital. Ind O Patient has severe anti-NMDA receptor autoimmune and O Treatment with steroids and intravenous active disease O At least one other immunosuppressant (effective at controlling active disease or O Rapid treatment is required due to life threaten and	immunoglobulin and/or plasma exchange has not been effective at controlling cyclophosphamide, ciclosporin, tacrolimus, mycophenolate) has not been ning complications 75 mg/m2 of body surface area per week for a total of four weeks, or 500 mg once two weeks apart

Form RS1973 March 2025	HOSPITAL MEDICINES LIST Page 36 RESTRICTIONS CHECKLIST
	rictions for funding in the hospital setting . For more details, refer to Section H of the Pharmaceutical
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Rituximab (Riximyo) - continued	
CONTINUATION – CD20+ low grade or follicular B-c Re-assessment required after 24 months Prerequisites (tick boxes where appropriate)	ell NHL
Rituximab is to be used for maintenanc chemotherapy	e in CD20+ low grade or follicular B-cell NHL following induction with first-line systemic
	maintenance therapy for 2 years at a dose of 375 mg/m2 every 8 weeks (maximum of
INITIATION – Membranous nephropathy Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate)	
or O Patient has PLA2 antibodies with	y/idiopathic membranous nephropathy* no evidence of secondary cause, and an eGFR of > 60ml/min/1.73m2 sion to end-stage kidney disease despite more than 3 months of treatment with conservative
O The total rituximab dose would not exce	eed the equivalent of 375mg/m2 of body surface area per week for a total of 4 weeks
CONTINUATION – Membranous nephropathy Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate)	
Patient was previously treated with rituand	kimab for membranous nephropathy*
or treatment	viously successful, but the condition has relapsed, and the patient now requires repeat e to treatment and requires repeat treatment (see Note)
and O The total rituximab dose used would no	ot exceed the equivalent of 375 mg/m2 of body surface area per week for a total of 4 weeks
Note:	
a) Indications marked with * are unapproved indication	
	e defined as > 5g/day proteinuria. ystem blockade, blood-pressure management, dietary sodium and protein restriction, treatment of ontraindicated or the patient has experienced intolerable side effects.
	ia of at least 50% from baseline, and between 0.3 grams and 3.5 grams per 24 hours.

PRESCRIB	ER	PATIENT:	
Name:	Name:Name:		
Ward:	/ard: NHI:		
Rituxima	b (Riximyo) - <i>continued</i>		
Re-assess	INITIATION – B-cell acute lymphoblastic leukaemia/lymphoma* Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)		
and (and	O Treatment must be in combination with an intensive chemotherapy protocol with curative intent		
Note: India	cations marked with * are unapproved indications.		
Re-assess	INITIATION – desensitisation prior to transplant Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate) O Patient requires desensitisation prior to mismatched allogenic stem cell transplant*		
and			
Note: India	cations 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 specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
and			
	O Patient has severe rapidly progressive pemphigus and		
	O Is used in combination with systemic corticosteroids (20	mg/day)	
	and O Skin involvement is at least 5% body surface area or O Significant mucosal involvement (10 or more mucosal erosions) or diffuse gingivitis or confluent large erosions or O Involvement of two or more mucosal sites		
or			
	Patient has pemphigus and Patient has not experienced adequate clinical benefit from systemic corticosteroids (20 mg/day) in combination with a steroid sparing agent, unless contraindicated		
Note: India	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			
CONTINUATION – pemiphigus* Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a dermatologist or relevant spectory by the Health NZ Hospital.	cialist, or in accordance with a protocol or guideline that has been endorsed		
 Patient has experienced adequate clinical benefit from rituxim ulceration and reduction in corticosteroid requirement and Patient has not received rituximab in the previous 6 months 	hab treatment, with improvement in symptoms and healing of skin		
Note: Indications marked with * are unapproved indications.			
INITIATION – immunoglobulin G4-related disease (IgG4-RD*) Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate)			
O Patient has confirmed diagnosis of IgG4-RD*			
or O Treatment with corticosteroids and/or disease modifying	g anti-rheumatic drugs for at least 3 months has been ineffective in hisone equivalent) without relapse g anti-rheumatic drugs is contraindicated or associated with evidence of		
and O Total rituximab dose used should not exceed a maximum of two 1000 mg infusions of rituximab given two weeks apa			
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	successful and patient's disease has demonstrated sustained response,		
or O Patient is receiving maintenance treatment for IgG4-RD	*		
and O Rituximab re-treatment not to be given within 6 months of previous course of treatment and O Maximum of two 1000 mg infusions of rituximab given two weeks apart			
		Note: Indications marked with * are unapproved indications.	

I confirm that the above details are correct:

Signed: Date:

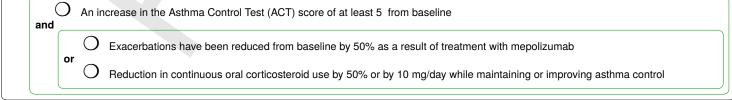
Use this checklist to determine if a patient meets the restrictions for funding in the hospital setting. For more details, refer to Section H of the Pharmaceutical Schedule. For community funding, see the Special Authority Criteria.

PRESCRIBER	PATIENT:	
Name:	Name:	
Vard:	NHI:	
/lepolizumab		
INITIATION – Severe eosinophilic asthma Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)		
O Prescribed by, or recommended by a respiratory physician or clinica endorsed by the Health NZ Hospital.	I immunologist, or in accordance with a protocol or guideline that has been	
O Patient must be aged 12 years or older and		
\sim	documented by a respiratory physician or clinical immunologist	
O Conditions that mimic asthma eg. vocal cord dysfunction, cer	tral 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 single maintenance and reliever therapy regimen, unless contraindicated or not tolerated 		
	at least the equivalent of 10 mg per day over the previous 3 months	
and O Treatment is not to be used in combination with subsidised be and	nralizumab	
O Patient has an Asthma Control Test (ACT) score of 10 or less and oral corticosteroid dose must be made at the time of appl response to treatment	. Baseline measurements of the patient's asthma control using the ACT ication, and again at around 52 weeks after the first dose to assess	
and O Patient has not previously received an anti-IL5 biologica	al therapy for their severe eosinophilic asthma	
O Patient was refractory or intolerant to previous and	ti-IL5 biological therapy	
O Patient was not eligible to continue treatment with 12 months of commencing treatment	previous anti-IL5 biological therapy and discontinued within	

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



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, leflue 	m at least one of the following for at least three months (unless nomide, methotrexate, mycophenolate, or rituximab
	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:

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:	
Casirivimab and imdevimab		
INITIATION – Treatment of profoundly immunocompromised patients Re-assessment required after 2 weeks		
Prerequisites (tick boxes where appropriate)		
O Patient has confirmed (or probable) COVID-19		
O The patient is in the community (treated as an outpatient) wi	th mild to moderate disease severity*	
and Patient is profoundly immunocompromised** and is at risk of not having mounted an adequate response to vaccination against COVID-19 or is unvaccinated and Patient's symptoms started within the last 10 days		
		And Patient is not receiving high flow oxygen or assisted/mechanical ventilation
and O Casirivimab and imdevimab is to be administered at a maximum dose of no greater than 2,400 mg		
Note: * Mild to moderate disease severity as described on the Ministry of Health Website ** Examples include B-cell depletive illnesses or patients receiving treatment that is B-Cell depleting.		
INITIATION – mild to moderate COVID-19-hospitalised patients Re-assessment required after 2 weeks		
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	
And Patient has confirmed (or probable) COVID-19		
O Patient is an in-patient in hospital with mild to moderate dise	ase severity*	
and O Patient's symptoms started within the last 10 days		
and O Patient is not receiving high flow oxygen or assisted/mechan	ical ventilation	
O Age > 50		
or O BMI > 30		
O Patient is Māori or Pacific ethnicity		

O Patient is at increased risk of severe illness from COVID-19, excluding pregnancy, as described on the Ministry of Health website (see Notes)

	and	_					
		or	0	Patient is unvaccinated			
			0	Patient is seronegative where serology testing is readily available or strongly suspected to be seronegative where serology testing is not available			
	and	_					
		Ο	Casir	ivimab and imdevimab is to be administered at a maximum dose of no greater than 2,400 mg			
Note	: * Mi	ld to	mode	rate disease severity as described on the Ministry of Health Website			
**(<mark>ht</mark>	tps://w	ww.	health	.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-information-specific-audiences/covid-19-advice-			
high	nigher-risk-people)						

RS2063 - Adalimumab (Amgevita)

Arthritis - oligoarticular course juvenile idiopathic - INITIATION	381
Arthritis - oligoarticular course juvenile idiopathic - CONTINUATION	
Arthritis - polyarticular course juvenile idiopathic - INITIATION	
Arthritis - polyarticular course juvenile idiopathic - CONTINUATION	
Arthritis - psoriatic - INITIATION	
Arthritis - psoriatic - CONTINUATION	
Arthritis - rheumatoid - INITIATION	
Arthritis - rheumatoid - CONTINUATION	
Behcet's disease - severe - INITIATION	
Crohn's disease - adults - INITIATION	
Crohn's disease - adults - CONTINUATION	
Crohn's disease - children - INITIATION	
Crohn's disease - children - CONTINUATION	
Crohn's disease - fistulising - INITIATION	
Crohn's disease - fistulising - CONTINUATION	
Hidradenitis suppurativa - INITIATION	
Hidradenitis suppurativa - CONTINUATION	
Ocular inflammation - chronic - INITIATION	
Ocular inflammation - chronic - CONTINUATION	
Ocular inflammation - severe - INITIATION	
Ocular inflammation - severe - CONTINUATION	
Plaque psoriasis - severe chronic - INITIATION	
Plaque psoriasis - severe chronic - CONTINUATION	
Still's disease - adult-onset (AOSD) - INITIATION	
Ankylosing spondylitis - INITIATION	
Ankylosing spondylitis - CONTINUATION	
Inflammatory bowel arthritis - axial - INITIATION	
Inflammatory bowel arthritis - axial - CONTINUATION	
Inflammatory bowel arthritis – peripheral - INITIATION	
Inflammatory bowel arthritis – peripheral - CONTINUATION	
Inflammatory bowel arthritis – peripheral - CONTINUATION Pyoderma gangrenosum - INITIATION Ulcerative colitis - INITIATION	
Ulcerative colitis - INITIATION	
Ulcerative colitis - CONTINUATION	
Undifferentiated spondyloarthiritis - INITIATION	
Undifferentiated spondyloarthiritis - CONTINUATION	
	J

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 (Amgevita)

INITIATION – Behcet's disease - severe

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. and

(and	patient has severe Behcet's disease* that is significantly impacting the patient's quality of life		
		tre	The patient has severe ocular, neurological, and/or vasculitic symptoms and has not responded adequately to one or more treatment(s) appropriate for the particular symptom(s)
	or	0	The patient has severe gastrointestinal, rheumatological and/or mucocutaneous symptoms and has not responded adequately to two or more treatments appropriate for the particular symptom(s)
to: India		no m	arked with * are unapproved indications

dications marked with * are unapproved indicati

INITIATION – Hidradenitis suppurativa Re-assessment required after 4 months

and

Prerequisites (tick boxes where appropriate)

\bigcirc	Prescribed by, or recommended by a dermatologist, or	in accordance	with a protocol or	r guideline that has been endorsed by the Health Na	Ζ
	Hospital.				
and					

\cup	Patient has hidradenitis suppurativa Hurley Stage II or Hurley Stage III lesions in distinct anatomic areas
and	
\bigcirc	Patient has tried, but had an inadequate response to at least a 90 day trial of systemic antibiotics or patient has demonstrated
-	intolerance to or has contraindications for systemic antibiotics
and	

() Patient has 3 or more active lesions

The patient has a DLQI of 10 or more and the assessment is no more than 1 month old at time of application

Re-ass	TINUATION – Hidradenitis suppurativa sessment required after 2 years						
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 endorsed by the Health							
and	NZ Hospital.						
a	O The patient has a reduction in active lesions (e.g. inflammatory nodules, abscesses, draining fistulae) of 25% or more from baseline and						
	O The patient has a DLQI improvement of 4 or more from baseline						

PRES	SCRIE	BER		PATIENT:			
Name	e:			Name:			
Ward	:			NHI:			
Adal	imu	mab	(An	gevita) - continued			
Re-a	INITIATION – Plaque psoriasis - severe chronic Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)						
(and		Prescri Hospita		y, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ			
		and	C	Patient has had an initial Special Authority approval for etanercept for severe chronic plaque psoriasis			
			or	 Patient has experienced intolerable side effects Patient has received insufficient benefit to meet the renewal criteria for etanercept for severe chronic plaque psoriasis 			
	or		_				
			or	 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 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 			
			or	 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 			
			С	Patient has tried, but had an inadequate response to, or has experienced intolerable side effects from, at least three of the ollowing (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, ciclosporin, or acitretin			
		(С	A PASI assessment or (DLQI) assessment has been completed for at least the most recent prior treatment course but no onger than 1 month following cessation of each prior treatment course and is no more than 1 month old at the time of application			

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Adalimumab (Amgevita) - continued	
CONTINUATION – Plaque psoriasis - severe chronic Re-assessment required after 2 years	
Prerequisites (tick boxes where appropriate)	
O Patient had "whole body" severe chronic plaque psorias	is at the start of treatment

	or	 O 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 O The patient has a DLQI improvement of 5 or more, when compared with the pre-treatment baseline value
and	C	Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment
	or	 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 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
	~	
and)	Patient 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
		O Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing adalimumab
	(and (and (and	or and and

INITIATION – pyoderma gangrenosum								
Prerequisites (tick boxes where appropriate)								
an	O Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health Hospital.							
	and	0 d O	Patient has pyoderma gangrenosum* Patient has received three months of conventional therapy including a minimum of three pharmaceuticals (e.g. prednisone, ciclosporin, azathioprine, or methotrexate) and not received an adequate response					
No	te: Inc	dicatio	ons marked with * are unapproved indications.					

PRES	CRIB	ER		PATIENT:				
Name	:			Name:				
Ward:				NHI:				
Adal	dalimumab (Amgevita) - continued							
INITIATION – Crohn's disease - adults Re-assessment required after 6 months 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.								
	(and	Ο	Patient has severe active Crohn's disease					
		or or	 O Patient has a CDAI score of greater than or equal to 300 O Patient has extensive small intestine disease affecting m O Patient has evidence of short gut syndrome or would be 					
		or	O Patient has an ileostomy or colostomy and has intestinal	inflammation				
	and (0	Patient has tried but had an inadequate response to, or has ex and corticosteroids	perienced intolerable side effects from, prior therapy with immunomodulators				
Re-a	ssess equis C	ites Presc	 N – Crohn's disease - adults t required after 2 years (tick boxes where appropriate) bribed by, or recommended by any relevant practitioner, or in ac ospital. 	cordance with a protocol or guideline that has been endorsed by the Health				
	(or	О	CDAI score has reduced by 100 points from the CDAI score, o adalimumab	r HBI score has reduced 3 points, from when the patient was initiated on				
	(or	Ο	CDAI score is 150 or less, or HBI is 4 or less					
	(Ο	The patient has demonstrated an adequate response to treatment	nent, but CDAI score and/or HBI score cannot be assessed				
Re-a	INITIATION – Crohn's disease - children Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)							
and		Preso NZ H	ospital.	cordance with a protocol or guideline that has been endorsed by the Health				
	(and	O or	Paediatric patient has active Crohn's disease O Patient has a PCDAI score of greater than or equal to 30					
			O Patient has extensive small intestine disease					
	and (О	Patient has tried but had an inadequate response to, or has ex and corticosteroids	perienced intolerable side effects from, prior therapy with immunomodulators				

Form RS2063 March 2025	RESTRICTIONS CHECKLIST
Use this checklist to determine if a patient meets the re Schedule. For community funding, see the Special Au	strictions for funding in the hospital setting . For more details, refer to Section H of the Pharmaceutica thority Criteria.
PRESCRIBER	PATIENT:
Name:	
Ward:	
Adalimumab (Amgevita) - continued	
CONTINUATION – Crohn's disease - children Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by any rele NZ Hospital.	evant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
$\bigcap \mathcal{A}$	ts from the PCDAI score when the patient was initiated on adalimumab
O PCDAI score is 15 or less	
\sim	equate response to treatment but PCDAI score cannot be assessed
A Prescribed by, or recommended by any relevant NZ Hospital.	e
O Patient has one or more comple	ex externally draining enterocutaneous fistula(e)
O Patient has one or more rectova	aginal fistula(e)
O Patient has complex peri-anal f	stula
A Baseline Fistula Assessment has b	een completed and is no more than 1 month old at the time of application
CONTINUATION – Crohn's disease - fistulising Re-assessment required after 2 years Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant NZ Hospital.	evant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
	have decreased from baseline by at least 50%
\sim	n drainage of all fistula(e) from baseline as demonstrated by a reduction in the Fistula Assessment nd patient-reported pain
${ m O}$ There has been a marked reduction in	

or

or

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.

PRE	SCRI	BER			PATIENT:			
Nam	Name:Name:							
Ward	ł:				NHI:			
Ada	limu	ımab	o (Ar	nge	gevita) - continued			
Re-a	asses	smen	t requ	ired	nflammation - chronic ed after 4 months			
and	0		ribed	by, c	xes where appropriate) y, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that l	nas been endorsed by the Health		
	or	0	The	oatie	tient has had an initial Special Authority approval for infliximab for chronic ocular inflammation			
		and	0 a_	Pati loss	Patient has severe uveitis uncontrolled with treatment of steroids and other immunosuppressants v pss	vith a severe risk of vision		
			or	0	O Patient is 18 years or older and treatment with at least two other immunomodulatory agents l			
			or	\bigcirc	O Patient is under 18 years and treatment with methotrexate has proven ineffective or is not tole O			
				U	Patient is under 8 years and treatment with steroids or methotrexate has proven ineffective of therapeutic dose; or disease requires control to prevent irreversible vision loss prior to achieve methotrexate			
\subseteq								
Re-a	asses	smen	t requ	ired	ular inflammation - chronic ed after 2 years xes where appropriate)			
and		Presc NZ He			y, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that l	has been endorsed by the Health		
	(Ο	The	oatie	tient has had a good clinical response following 12 weeks' initial treatment			

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)

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:

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	ə:				
Ward	:		NHI:		
Ada	limu	ımab	(Amgevita) - continued		
Re-a	asses	sment	Cular inflammation - severe required after 4 months tick boxes where appropriate)		
and	0	Presc	ribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.		
	or	0	Patient has had an initial Special Authority approval for infliximab for severe ocular inflammation		
		and	O Patient has severe, vision-threatening ocular inflammation requiring rapid control		
			O Treatment with high-dose steroids (intravenous methylprednisolone) followed by high dose oral steroids has proven ineffective at controlling symptoms		
			O Patient developed new inflammatory symptoms while receiving high dose steroids or		
			O Patient is aged under 8 years and treatment with high dose oral steroids and other immunosuppressants has proven ineffective at controlling symptoms		
\subseteq					
Re-a	asses	sment	N – Ocular inflammation - severe required after 2 years tick boxes where appropriate)		
O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by NZ Hospital.					
	or	0	The patient has had a good clinical response following 3 initial doses		
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)					

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	PATIENT:				
Name:	Name:				
Ward:	NHI:				
Adolimumoh (Amgovita)					

Adalimumab (Amgevita) - continued

Re-asses	INITIATION – ankylosing spondylitis 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 He Hospital.						
	and	0	Patient has had an initial Special Authority approval for etanercept for ankylosing spondylitis			
		or	O The patient has experienced intolerable side effects			
			O The patient has received insufficient benefit to meet the renewal criteria for ankylosing spondylitis			
or						
		Ο	Patient has a confirmed diagnosis of ankylosing spondylitis for more than six months			
	and	Ο	Patient has low back pain and stiffness that is relieved by exercise but not by rest			
	and	Ο	Patient has bilateral sacroiliitis demonstrated by radiology imaging			
		Ο	Patient has not responded adequately to treatment with two or more NSAIDs, while patient was undergoing at least 3 months of a regular exercise regimen for ankylosing spondylitis			
	and	I				
		or	O 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)			
			O Patient has limitation of chest expansion by at least 2.5 cm below the average normal values corrected for age and gender			
	and	0	A BASDAI of at least 6 on a 0-10 scale completed after the 3 month exercise trial, but prior to ceasing any previous pharmacological treatment and is no more than 1 month old at the time of application			

CONTINUATION – ankylosing spondylitis Re-assessment required after 2 years

Prerequisites (tick box where appropriate)

 \bigcirc

 \bigcirc

and

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.

For applications where 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

PRES	SCRIE	BER	PATIENT:
Name):		
Ward	:		NHI:
Adal	imu	mat	b (Amgevita) - continued
INIT Re-a	ATIO ssess equis	N – / smen sites Preso	Arthritis - oligoarticular course juvenile idiopathic tt required after 6 months (tick boxes where appropriate) cribed by, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed e Health NZ Hospital.
Re-a	equis	smen sites Preso	DN – Arthritis - oligoarticular course juvenile idiopathic ht required 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 dospital.
and	or	0	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

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:			Name:	
Ward:			NHI:	
Adalin	num	ab (A	evita) - continued	
Re-ass	sessm quisit e) Pre	ient req es (tick escribed	- polyarticular course juvenile idiopathic d after 6 months es where appropriate) or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline th	at has been endorsed
and		and	NZ Hospital. atient has had an initial Special Authority approval for etanercept for polyarticular course juvenile idiopathic D Patient has experienced intolerable side effects	arthritis (JIA)
c			Patient has received insufficient benefit to meet the renewal criteria for polyarticular course JIA be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by top atient has had polyarticular course JIA for 6 months duration or longer	xicity or intolerance
		and or	 At least 5 active joints and at least 3 joints with limited range of motion, pain or tenderness after a 3-m methotrexate (at the maximum tolerated dose) Moderate or high disease activity (cJADAS10 score of at least 2.5) after a 3-month trial of methotrexate maximum tolerated dose) Low disease activity (cJADAS10 score between 1.1 and 2.5) after a 6-month trial of methotrexate 	
Re-ass	sessm	ient req	aritis - polyarticular course juvenile idiopathic d after 2 years es where appropriate)	
C		escribeo Z Hospit	or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been e	endorsed by the Health

O 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

and

or

HOSPITAL MEDICINES LIST

	For cor	nmu	nity fı	unding, see the Special Author	ity Criteria.
ESCRI	BER				PATIENT:
me:					Name:
rd:					NHI:
alimu	ımab	(An	ngev	vita) - continued	
e-asses	sment	requ	red a	osoriatic after 6 months where appropriate)	
	Prescri Hospita		by, or	r recommended by a rheumato	blogist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
	and	0	Patie	ent has had an initial Special A	authority approval for etanercept or secukinumab for psoriatic arthritis
		or	0 0	Patient has experienced intol Patient has received insuffici	lerable side effects ient benefit to meet the renewal criteria for psoriatic arthritis
	and and and	0	Patie		d to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated dose) d to at least three months of sulfasalazine or leflunomide at maximum tolerated doses
		or	0 0	Patient has persistent sympton	oms of poorly controlled and active disease in at least 15 swollen joints oms of poorly controlled and active disease in at least four joints from the following: wrist,
	and			elbow, knee, ankle, and eithe	er shoulder or hip
		or	0		er than 15 mg/L measured no more than one month prior to the date of this application R greater than 25 mm per hour
		or	0	ESR and CRP not measured and has done so for more that	d as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day an three months
ΝΤΙΝΙ				tis - psoriatic after 2 years	

Ο Following initial treatment, the patient has at least a 50% decrease in swollen joint count from baseline and a clinically significant response in the opinion of the physician

Ο Patient demonstrates at least a continuing 30% improvement in swollen joint count from baseline and a clinically significant response in the opinion of the treating physician

I confirm that the above details are correct:

or

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	SCRIE	BER		PATIENT:
Nam	e:			Name:
Ward	d:			NHI:
Ada	limu	mab	(An	ngevita) - continued
Re-a	assess requis	sment sites (t	requ ick b bed	is - rheumatoid 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
		and	О	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 rheumatoid arthritis
	or	and and and and	O O O or	 Patient has had rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic citrullinated peptide (CCP) antibody positive) for six months duration or longer Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance 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 methotrexate in combination with sulfasalazine and hydroxychloroquine sulphate at maximum tolerated doses (unless contraindicated) Patient has tried and not responded to at least three months of methotrexate in combination with sulfasalazine and hydroxychloroquine sulphate at maximum tolerated doses (unless contraindicated) Patient has tried and not responded to at least three months of methotrexate in combination with the maximum tolerated dose of ciclosporin 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 Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen 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
Re-a	assess requis	sment sites (t	requ ick b bed	rthritis - rheumatoid red after 2 years 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			
	or	0	Following 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
		\sim	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

				etermine if a patient meets the restrictions for funding in the hospital setting . For more details, refer to Section H of the Pharmaceutical nity funding, see the Special Authority Criteria.
PRES	SCRI	BER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Adal	imu	ımab	(Am	ngevita) - continued
				disease - adult-onset (AOSD) oxes where appropriate)
(and		Presci Hospit		by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
		and	0	The patient has had an initial Special Authority approval for etanercept and/or tocilizumab for (AOSD)
			or	O Patient has experienced intolerable side effects from etanercept and/or tocilizumab
				O Patient has received insufficient benefit from at least a three-month trial of etanercept and/or tocilizumab
	or	and	0	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
Re-a	isses equi: C	sment sites (requi tick b ribed	tive colitis ired after 6 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 I.
and	(and and		Patier	nt has active ulcerative colitis
		or	0	Patient's SCCAI score is greater than or equal to 4
		Ο		Patient's PUCAI score is greater than or equal to 20 In thas tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators ystemic corticosteroids
	and	\sim	Surge	ery (or further surgery) is considered to be clinically inappropriate
Re-a	isses equi:	sment sites (t requi (tick b ribed	Icerative colitis ired after 2 years 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				CCAI score has reduced by 2 points or more from the SCCAI score when the patient was initiated on biologic therapy
	or	\frown		PUCAI score has reduced by 10 points or more from the PUCAI score when the patient was initiated on biologic therapy

Forn March	n RS20		HOSPITAL MEDICINES LIST Page 33 RESTRICTIONS CHECKLIST Page 33		
Use th	is checkl		the hospital setting . For more details, refer to Section H of the Pharmaceut	tical	
PRES	CRIBER		PATIENT:		
Name	:		Name:		
Ward:			NHI:		
Adali	imuma	b (Amgevita) - continued			
Re-as	ssessme	undifferentiated spondyloarthiritis nt required after 6 months			
Prere	equisites	(tick boxes where appropriate)			
and		cribed by, or recommended by a rheumatologist, or in accorda pital.	ance with a protocol or guideline that has been endorsed by the Health NZ		
	and	Patient has undifferentiated peripheral spondyloarthritis* with wrist, elbow, knee, ankle, and either shoulder or hip	n active peripheral joint arthritis in at least four joints from the following:		
	and	Patient has tried and not responded to at least three months tolerated doses (unless contraindicated)	of each of methotrexate, sulphasalazine and leflunomide, at maximum		
	or		ed no more than one month prior to the date of this application		
	o		sured no more than one month prior to the date of this application		
		O ESR and CRP not measured as patient is currently rec has done so for more than three months	ceiving prednisone therapy at a dose of greater than 5 mg per day and		
Note:	Indicatio	ons marked with * are unapproved indications.			
Re-as	ssessmer equisites O Pres	ON – undifferentiated spondyloarthiritis nt required after 2 years (tick boxes where appropriate) scribed by, or recommended by any relevant practitioner, or in a Hospital.	accordance with a protocol or guideline that has been endorsed by the Heal	th	
	O or	Following initial treatment, the patient has at least a 50% dec response to treatment in the opinion of the physician	crease in active joint count from baseline and a clinically significant		
	Ö	The patient demonstrates at least a continuing 30% improven response in the opinion of the treating physician	ment in active joint count from baseline and a clinically significant		
Re-as	ssessmer equisites		ance with a protocol or guideline that has been endorsed by the Health NZ		
) and	Patient has a diagnosis of active ulcerative colitis or active C	rohn's disease		
	0	Patient has axial inflammatory pain for six months or more			
	and	Patient is unable to take NSAIDs			
	and O and	Patient has unequivocal sacroiliitis demonstrated by radiolog	ical imaging or MRI		
	0	Patient has not responded adequately to prior treatment consphysiotherapist	sisting of at least 3 months of an exercise regime supervised by a		
	and	A BASDAI of at least 6 on a 0-10 scale completed after the 3 treatment	3 month exercise trial, but prior to ceasing any previous pharmacological		

		to determine if a patient meets the restrictions for funding in the hospital setting . For more details, refer to Section H of the Pharmaceutical mmunity funding, see the Special Authority Criteria.
PRES	CRIBEF	PATIENT:
Name	:	Name:
Ward		NHI:
Adal	imuma	(Amgevita) - continued
Re-a	ssessme equisite Pre NZ	 I - inflammatory bowel arthritis – axial required after 2 years ick box where appropriate) ibed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health spital. treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10 point scale, or an ement in BASDAI of 50%, whichever is less
Re-a	ssessme equisite	flammatory bowel arthritis – peripheral required after 6 months ick boxes where appropriate) ibed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ al.
	and and and and o	 Patient has a diagnosis of active ulcerative colitis or active Crohn's disease Patient has active arthritis in at least four joints from the following: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder, sternoclavicular Patient has tried and not experienced a response to at least three months of methotrexate, or azathioprine at a maximum tolerated dose (unless contraindicated) Patient has tried and not experienced a response to at least three months of sulphasalazine at a maximum tolerated dose (unless contraindicated) Patient has a CRP level greater than 15 mg/L measured no more than one month prior to the date of this application Patient has an 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-a	ssessme equisite O Pre	 I – inflammatory bowel arthritis – peripheral required after 2 years ick boxes where appropriate) ibed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health spital. Following initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant esponse to treatment in the opinion of the physician

O 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:

or

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:

Palivizumab

and	$\overline{\mathbf{A}}$			where appropriate) to be administered during the annual RSV season
anu	or	and	С О	Infant was born in the last 12 months Infant was born at less than 32 weeks zero days' gestation
		and	C or	Child was born in the last 24 months O Child has severe lung, airway, neurological or neuromuscular disease that requires ongoing ventilatory/respiratory support (see Note A) in the community O Child has haemodynamically significant heart disease
				and O Child has unoperated simple congenital heart disease with significant left to right shunt (see Note B) or O Child has unoperated or surgically palliated complex congenital heart disease or O Child has severe pulmonary hypertension (see Note C) or O Child has moderate or severe left ventricular (LV) failure (see Note D)
			or or	 Child has severe combined immune deficiency, confirmed by an immunologist, but has not received a stem cell transplant Child has inborn errors of immunity (see Note E) that increase susceptibility to life-threatening viral respiratory 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 - continue	ed	
CONTINUATION Re-assessment required a Prerequisites (tick boxes		
and O Child was	born in the last 24 months Id has severe lung, airway, neurological or neuromus e A) in the community	cular disease that requires ongoing ventilatory/respiratory support (see
and of other	$\stackrel{\text{rr}}{\sim} O$ Child has unoperated or surgically palliated $\stackrel{\text{rr}}{\circ} O$ Child has severe pulmonary hypertension (s	rt disease with significant left to right shunt (see Note B) complex congenital heart disease ee Note C)
or O Chil		d by an immunologist, but has not received a stem cell transplant rease 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

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:

Gemtuzumab ozogamicin

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

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:

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:
nralizumab	
ITIATION – Severe eosinophilic asthma e-assessment required after 12 months erequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a respiratory physician endorsed by the Health NZ Hospital.	or clinical immunologist, or in accordance with a protocol or guideline that has been
A Patient must be aged 12 years or older	
\sim	asthma documented by a respiratory physician or clinical immunologist
\sim	ction, central airway obstruction, bronchiolitis etc. have been excluded
O Patient has a blood eosinophil count of greater than (and	0.5 × 10°9 cells/L in the last 12 months
	by including inhaled corticosteroids (equivalent to at least 1000 mcg per day of ist, or budesonide/formoterol as part of the anti-inflammatory reliever therapy plus tolerated
O Patient has had at least 4 exacerbations needin defined as either documented use of oral cortic	ing systemic corticosteroids in the previous 12 months, where an exacerbation is costeroids for at least 3 days or parenteral corticosteroids
or O Patient has received continuous oral corticoste	eroids of at least the equivalent of 10 mg per day over the previous 3 months
and O Treatment is not to be used in combination with subs and	sidised mepolizumab
O Patient has an Asthma Control Test (ACT) score of 1	0 or less. Baseline measurements of the patient's asthma control using the ACT ne of application, and again at around 52 weeks after the first dose to assess
and	biological therapy for their severe eosinophilic asthma
O Patient was refractory or intolerant to pre	evious anti-IL5 biological therapy
\sim	ment with previous anti-IL5 biological therapy and discontinued within

CONTINUATION – Severe eosinophilic asthma Re-assessment required after 2 years

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.

(and	С	An in	crease in the Asthma Control Test (ACT) score of at least 5 from baseline
	or	Ο	Exacerbations have been reduced from baseline by 50% as a result of treatment with benralizumab
		0	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:

Ustekinumab

INITIATION – Crohn's disease - adults Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)
O Patient is currently on treatment with ustekinumab commenced prior to 1 February 2023 and met all remaining criteria (criterion 2) below at the time of commencing treatment
or O Patient has active Crohn's disease
Patient has had an initial approval for prior biologic therapy for Crohn's disease and has experienced intolerable side effects or insufficient benefit to meet renewal criteria
O Patient meets the initiation criteria for prior biologic therapies for Crohn's disease and O ther biologics for Crohn's disease are contraindicated
CONTINUATION – Crohn's disease - adults Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)
CDAI score has reduced by 100 points, or HBI score has reduced by 3 points, from when the patient was initiated on biologic therapy
or O CDAI score is 150 or less, or HBI is 4 or less
O The patient has experienced an adequate response to treatment, but CDAI score and/or HBI score cannot be assessed and O Ustekinumab to be administered at a dose no greater than 90 mg every 8 weeks
INITIATION – Crohn's disease - children* Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)
O Patient is currently on treatment with ustekinumab commenced prior to 1 February 2023 and met all remaining criteria (criterion 2) below at the time of commencing treatment
Patient has active Crohn's disease and Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria Patient meets the initiation criteria for prior biologic therapies for Crohn's disease and O Other biologics for Crohn's disease are contraindicated
Note: Indication marked with * is an unapproved indication.

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:
ne:	Name:
rd:	NHI:
tekinumab - continued	
DNTINUATION – Crohn's disease - children* e-assessment required after 12 months erequisites (tick boxes where appropriate)	
or O PCDAI score is 15 or less	ts from when the patient was initiated on biologic therapy guate response to treatment, but CDAI score cannot be assessed
and O Ustekinumab to administered at a dose no o ote: Indication marked with * is an unapproved indication.	greater than 90 mg every 8 weeks
-assessment required after 6 months	
e-assessment required after 6 months erequisites (tick boxes where appropriate) O Patient is currently on treatment with usteking below at the time of commencing treatment O Patient has active ulcerative colitis	numab commenced prior to 1 February 2023 and met all remaining criteria (criterion 2)
erequisites (tick boxes where appropriate) Patient is currently on treatment with usteking below at the time of commencing treatment or Patient has active ulcerative colitis and Patient has had an initial approvely effects or insufficient benefit to or Patient meets the initiation and	val for prior biologic therapy for ulcerative colitis and has experienced intolerable side
erequisites (tick boxes where appropriate) Patient is currently on treatment with usteking below at the time of commencing treatment or Patient has active ulcerative colitis and Patient has had an initial approvely effects or insufficient benefit to or Patient meets the initiation and	val for prior biologic therapy for ulcerative colitis and has experienced intolerable side meet renewal criteria on criteria for prior biologic therapies for ulcerative colitis
erequisites (tick boxes where appropriate) Patient is currently on treatment with usteking below at the time of commencing treatment or Patient has active ulcerative colitis and Patient has had an initial approvely effects or insufficient benefit to or Patient meets the initiatio and Other biologics for ulcerative colitis erequisites (tick boxes where appropriate) ONTINUATION – ulcerative colitis erequisites (tick boxes where appropriate) The SCCAI score has reduced by 2 p	val for prior biologic therapy for ulcerative colitis and has experienced intolerable side meet renewal criteria on criteria for prior biologic therapies for ulcerative colitis

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:

Vedolizumab

(Ο	Patie	ent has active Crohn's disease
and		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	Ο	Patient has a CDAI score of greater than or equal to 300, or HBI score of greater than or equal to 10
	or	Ο	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
	or	0	Patient has an ileostomy or colostomy, and has intestinal inflammation
and			
		0	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
	or	Ο	Patient has experienced intolerable side effects from immunomodulators and corticosteroids
	or	Ο	Immunomodulators and corticosteroids are contraindicated
			Crohn's disease - adults
			uired after 2 years boxes where appropriate)
	Or	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
	or	Ο	CDAI score is 150 or less, or HBI is 4 or less
	or	-	

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:
Vedolizumab - continued	

	Ο	Paediatric patient has active Crohn's disease
and		
	or	O 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	O Patient has a Paediatric Crohn's Disease Activity Index (PCDAI) score of greater than or equal to 30
		O Patient has extensive small intestine disease
and	_	
		O 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
	or	m O Patient has experienced intolerable side effects from immunomodulators and corticosteroids
		O Immunomodulators and corticosteroids are contraindicated
Indic	catio	on marked with * is an unapproved indication.
TINU	ΑΤΙΟ	ON – Crohn's disease - children*
		nt required after 2 years
equis	ites	(tick boxes where appropriate)

O The patient has experienced an adequate response to treatment, but CDAI score cannot be assessed

 ${
m O}\,$ Vedolizumab to administered at a dose no greater than 300mg every 8 weeks

Note: Indication marked with * is an unapproved indication.

or

and

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:

Vedolizumab - continued

Re-assessment requ	
Prerequisites (tick)	boxes where appropriate)
and Patie	ent has active ulcerative colitis
Ο	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 O	Patient has a SCCAI score is greater than or equal to 4
Ŭ O	Patient's PUCAI score is greater than or equal to 20*
and	
0	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
or O	Patient has experienced intolerable side effects from immunomodulators and corticosteroids
0	Immunomodulators and corticosteroids are contraindicated
Note: Indication ma	rked with * is an unapproved indication.
CONTINUATION – Re-assessment requ Prerequisites (tick	
O	The SCCAI score has reduced by 2 points or more from the SCCAI score since initiation on biologic therapy
or O	The PUCAI score has reduced by 10 points or more from the PUCAI score since initiation on biologic therapy *
and O Veda	plizumab will be used at a dose no greater than 300 mg intravenously every 8 weeks

Note: Indication marked with * is an unapproved indication.

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:	

Brentuximab

INITIATION – relapsed/refractory Hodgkin lymphoma Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)		
O Patient has relapsed/refractory CD30-positive Hodgkin lymphoma after two or more lines of chemotherapy and O Patient is ineligible for autologous stem cell transplant		
or O Patient has relapsed/refractory CD30-positive Hodgkin lymphoma and O Patient has previously undergone autologous stem cell transplant		
 and Patient has not previously received funded brentuximab vedotin and Response to brentuximab vedotin treatment is to be reviewed after a maximum of 6 treatment cycles and Brentuximab vedotin to be administered at doses no greater than 1.8 mg/kg every 3 weeks 		
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 brentuximab vedotin after 6 treatment cycles and Treatment remains clinically appropriate and the patient is benefitting from treatment and treatment is being tolerated Patient is to receive a maximum of 16 total cycles of brentuximab 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 anaplastic large cell lymphoma Patient has an ECOG performance status of 0-1 		

Patient has not previously received brentuximab vedotin

Response to brentuximab vedotin treatment is to be reviewed after a maximum of 6 treatment cycles

Brentuximab vedotin to be administered at doses no greater than 1.8 mg/kg every 3 weeks

and

and

and

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):		Name:
Ward	:		NHI:
Bren	tuxima	b - continued	
Re-a	ssessmer	DN – anaplastic large cell lymphoma It required after 9 months (tick boxes where appropriate)	
	O Patient has achieved a partial or complete response to brentuximab vedotin after 6 treatment cycles		ximab vedotin after 6 treatment cycles
	and Treatment remains clinically appropriate and the patient is benefitting from treatment and treatment is being tolerated		efitting from treatment and treatment is being tolerated
	and	Patient is to receive a maximum of 16 total cycles of brentuxim	ab vedotin 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:			
Ward:	NHI:		
Frastuzumab	(Herzuma)		
INITIATION – early breast cancer Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)			
and	O The patient has early breast cancer expressing HER-2 IHC 3+ or ISH + (including FISH or other current technology and O Maximum cumulative dose of 106 mg/kg (12 months' treatment)		
Re-assessment r	- early breast cancer* equired after 12 months ck boxes where appropriate)		
and	 The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology The patient received prior adjuvant trastuzumab treatment for early breast cancer 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 He cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab Trastuzumab will not be given in combination with pertuzumab 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 The patient has good performance status (ECOG grade 0-1) 		
or (and (and (and (C Trastuzumab to be discontinued at disease progression Patient has previously discontinued treatment with trastuzumab in the metastatic setting for reasons other than severe toxicity or disease progression Patient has signs of disease progression Disease has not progressed during previous treatment with trastuzumab 		
Note: * For patie	nts with relapsed HER-2 positive disease who have previously received adjuvant trastuzumab for early breast cancer		

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:
Trastuzumab (Herzuma) - continued	

ر and	O The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)		
	ar	O The patient has not previously received lapatinib treatment for HER-2 positive metastatic breast cancer	
	or	O The patient discontinued lapatinib within 3 months due to intolerable side effects and the cancer did not progress whilst on lapatinib	
and	_		
	O Trastuzumab will not be given in combination with pertuzumab		
		Trastuzumab to be administered in combination with pertuzumab	
		O 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	

CONTINUATION - metastatic breast cancer

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

	and	The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)
	and	The cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab
	O	Trastuzumab to be discontinued at disease progression
or		
	and	Patient has previously discontinued treatment with trastuzumab for reasons other than severe toxicity or disease progression
	Ο	Patient has signs of disease progression
	and	Disease has not progressed during previous treatment with trastuzumab

The patient has locally advanced or metastatic gastric, gastro-oesophageal junction or oesophageal cancer expressing HER-2 IHC 2+

INITIATION – gastric, gastro-oesophageal junction and oesophageal cancer Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)

Prerequisites (lick boxes where appropriate

 \bigcirc

and

O Patient has an ECOG score of 0-2

FISH+ or IHC3+ (or other current technology)

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 oesophage 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 p	previous 12 months whilst on trastuzumab
And Trastuzumab to be discontinued at 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 deruxtecan

Re-as		ent required after 6 months s (tick boxes where appropriate)
	C	Patient has metastatic breast cancer expressing HER-2 IHC3+ or ISH+ (including FISH or other current technology)
	and C and	Patient has previously received trastuzumab and chemotherapy, separately or in combination
		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	Patient has a good performance status (ECOG 0-1)
	and	Patient has not received prior funded trastuzumab deruxtecan treatment
	and	Treatment to be discontinued at disease progression
Re-as		ION ent required after 6 months s (tick boxes where appropriate)
	C	The cancer has not progressed at any time point during the previous approval period whilst on trastuzumab deruxtecan

O Treatment to be discontinued at disease progression

Note: Prior or adjuvant therapy includes anthracycline, other chemotherapy, biological drugs, or endocrine 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.

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	

Bevacizumab

	ssment required after 6 months isites (tick boxes where appropriate) O Patient is currently on treatment with bevacizumab, and met all remaining criteria prior to commencing treatment
or	Patient is currently on treatment with bevacizumab, and met an remaining citeria phoritic commencing treatment O Patient has locally advanced or metastatic, unresectable hepatocellular carcinoma and O Patient has preserved liver function (Child-Pugh A) and O Transarterial chemoembolisation (TACE) is unsuitable and O Patient has not received prior systemic therapy for the treatment of hepatocellular carcinoma or O Patient received funded lenvatinib before 1 March 2025 or O Patient has experienced treatment-limiting toxicity from treatment with lenvatinib and O No disease progression since initiation of lenvatinib
	and O Patient has an ECOG performance status of 0-2 and O To be given in combination with atezolizumab
Re-asses	UATION – unresectable hepatocellular carcinoma ssment required after 6 months isites (tick box where appropriate) No evidence of disease progression
Re-asses	ON – advanced or metastatic ovarian cancer ssment required after 4 months isites (tick boxes where appropriate)

	O The patient has previously untreated advanced (FIGO Stage IIIB or IIIC) epithelial ovarian, fallopian tube, or primary
	and
	O Debulking surgery is inappropriate
	or O The cancer is sub-optimally debulked (maximum diameter of any gross residual disease greater than 1cm)
and	

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:	
Bevacizumab - continued		
CONTINUATION – advanced or metastatic ovarian cancer Re-assessment required after 4 months		
Prerequisites (tick box where appropriate)		
O No evidence of disease progression		
INITIATION – Recurrent Respiratory Papillomatosis Re-assessment required after 12 months		
Prerequisites (tick boxes where appropriate)		
Maximum of 6 doses		
The patient has recurrent respiratory papillomatosis		
O The treatment is for intra-lesional administration		
CONTINUATION – Recurrent Respiratory Papillomatosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)		
Maximum of 6 doses		
The treatment is for intra-lesional administration		
O There has been a reduction in surgical treatments or disease	regrowth as a result of treatment	
INITIATION – Ocular Conditions Prerequisites (tick boxes where appropriate)		
O Ocular neovascularisation		
O Exudative ocular angiopathy		
)	

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	

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:	me: Name:		Name:	
Ward:	ard: NHI:			NHI:
Rituxima	b (M	abthe	era)	
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 NZ Hospital.				
	and	O	rheumatoid arthritis O The patient has experienced intolerable side effect	ty approval for at least one of etanercept and/or adalimumab for as from a reasonable trial of adalimumab and/or etanercept o and/or etanercept, the patient did not meet the renewal criteria for ritis
and				
	or	0	Rituximab to be used as an adjunct to methotrexate or le Patient is contraindicated to both methotrexate and leflur	
and	And O Maximum of two 1,000 mg infusions of rituximab given two weeks apart			

SCRIB	ER			PATIENT:
e:				Name:
:				NHI:
xima	b (N	labth	era) - continued	
			natoid arthritis - TNF inhibitors contraindicated uired after 4 months	
			poxes where appropriate)	
	Preso losp		by, or recommended by a rheumatologist, or in acco	rdance with a protocol or guideline that has been endorsed by the Health NZ
(С	Trea	tment with a Tumour Necrosis Factor alpha inhibitor is	s contraindicated
and (С		ent has had severe and active erosive rheumatoid art linated peptide (CCP) antibody positive) for six mont	hritis (either confirmed by radiology imaging, or the patient is cyclic hs duration or longer
and (and	С		ent has tried and not responded to at least three mon mum tolerated dose	ths of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a
and	С		tient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with sulfasalazine and droxychloroquine sulphate (at maximum tolerated doses)	
and		0	Patient has tried and not responded to at least three maximum tolerated dose of cyclosporin	e months of oral or parenteral methotrexate in combination with the
	or	0	Patient has tried and not responded to at least three gold	e months of oral or parenteral methotrexate in combination with intramuscula
	or	0	Patient has tried and not responded to at least three in combination with oral or parenteral methotrexate	e months of therapy at the maximum tolerated dose of leflunomide alone or
and		0		
	or	\bigcirc	Patient has persistent symptoms of poorly controlle	d and active disease in at least 20 swollen, tender joints
		Ο	Patient has persistent symptoms of poorly controlle knee, ankle, and either shoulder or hip	d and active disease in at least four joints from the following: wrist, elbow,
and	\subseteq			
	or	0	Patient has a C-reactive protein level greater than 1 application	5 mg/L measured no more than one month prior to the date of this
		0	C-reactive protein levels not measured as patient is day and has done so for more than three months	currently receiving prednisone therapy at a dose of greater than 5 mg per
and				
	or	O	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

O Maximum of two 1,000 mg infusions of rituximab given two weeks apart

I confirm that the above details are correct:

Signed: Date:

	BER			PATIENT:
ə:				Name:
:				NHI:
xima	ab (N	/labth [,]	era) - continued	
isses equi:	smen sites	it requ (tick t cribed	'heumatoid arthritis - re-treatment in 'partial re uired after 4 months poxes where appropriate) I by, or recommended by a rheumatologist, or in a	esponders' to rituximab
	or	0	count from baseline and a clinically significant re At 4 months following the second course of ritux from baseline and a clinically significant response At 4 months following the third and subsequent	hab infusions the patient had between a 30% and 50% decrease in active joint esponse to treatment in the opinion of the physician kimab infusions the patient had at least a 50% decrease in active joint count se to treatment in the opinion of the physician courses of rituximab infusions, the patient demonstrates at least a continuing eline and a clinically significant response to treatment in the opinion of the
and and	0	Ritux	kimab re-treatment not to be given within 6 month Rituximab to be used as an adjunct to methotres	
and	O	Maxi	imum of two 1,000 mg infusions of rituximab giver	
isses equi:	smen sites	it requ (tick t cribed	Theumatoid arthritis - re-treatment in 'responde uired after 4 months boxes where appropriate) I by, or recommended by a rheumatologist, or in a	ers' to rituximab
	or	0 0	baseline and a clinically significant response to At 4 months following the second and subseque	hab infusions the patient had at least a 50% decrease in active joint count from treatment in the opinion of the physician ent courses of rituximab infusions, the patient demonstrates at least a continuing eline and a clinically significant response to treatment in the opinion of the
	and O Rituximab re-treatment not to be given within 6 months of the previous course of treatment		ximab re-treatment not to be given within 6 month	s of the previous course of treatment
and	<u>ل</u>			
	l or	0	Rituximab to be used as an adjunct to methotree	xate or leflunomide therapy

RS1922 - Adalimumab (Humira - Alternative brand)

~	
Arthritis - polyarticular course juvenile idiopathic - INITIATION	418
Arthritis - polyarticular course juvenile idiopathic - CONTINUATION	
Arthritis - psoriatic - INITIATION	
Arthritis - psoriatic - CONTINUATION	419
Arthritis – oligoarticular course juvenile idiopathic - INITIATION	
Arthritis – oligoarticular course juvenile idiopathic - CONTINUATION	
Arthritis – rheumatoid - INITIATION	419
Arthritis – rheumatoid - CONTINUATION	
Behcet's disease – severe - INITIATION	
Behcet's disease – severe - CONTINUATION	
Crohn's disease - adult - INITIATION	
Crohn's disease - adult - CONTINUATION	
Crohn's disease - children - INITIATION	414
Crohn's disease - children - CONTINUATION	414
Crohn's disease - fistulising - INITIATION	
Crohn's disease - fistulising - CONTINUATION	
Hidradenitis suppurativa - INITIATION	
Hidradenitis suppurativa - CONTINUATION	
Ocular inflammation – chronic - INITIATION	
Ocular inflammation – chronic - CONTINUATION	
Ocular inflammation – severe - INITIATION	
Ocular inflammation – severe - CONTINUATION	
Psoriasis - severe chronic plaque - INITIATION	
Psoriasis - severe chronic plaque - CONTINUATION	
Pyoderma gangrenosum - INITIATION	
Pyoderma gangrenosum - CONTINUATION	
Still's disease – adult-onset (AOSD) - INITIATION	
Still's disease – adult-onset (AOSD) - CONTINUATION	
Ankylosing spondylitis - INITIATION	
Ankylosing spondylitis - CONTINUATION	

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:		
Nard:		
Adalimumab (Humira - Alternative brand)		
INITIATION – Behcet's disease – severe 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 by the Health NZ Hospital. and 		
or O 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		
 and O Patient has received a maximum of 6 months treatment with Amgevita and O Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication and O Adalimumab to be administered at doses no greater than 40 mg every 14 days 		
CONTINUATION – Behcet's disease – severe Re-assessment required after 6 months 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 endorsed by the Health NZ Hospital. and		
O The patient has had a good clinical response to treatment with and O Adalimumab to be administered at doses no greater than 40 m		
INITIATION - Hidradenitis suppurativa Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) 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.		
or		
and O Patient has previously had a Special Authority approval for the and O Adalimumab to be administered at doses no greater than 40 m		

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		
CONTINUATION – Hidradenitis suppurativa Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)		
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.		
The patient has a reduction in active lesions (e.g. inflammator	ry nodules, abscesses, draining fistulae) of 25% or more from baseline	
The patient has a Dermatology Quality of Life Index improvem and Adalimumab is to be administered at doses no greater than 40		
INITIATION – Psoriasis - severe chronic plaque Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)		
O Prescribed by, or recommended by a dermatologist or Practitioner or or guideline that has been endorsed by the Health NZ Hospital.	n the recommendation of a dermatologist, or in accordance with a protocol	
or	n adalimumab (Amgevita) following a minimum of 4 weeks treatment	
(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 O Patient has received a maximum of 6 months treatment with A and	mgevita	
O 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.	

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward: NHI:		
Adalimumab (Humira - Alternative brand) - continued		
CONTINUATION – Psoriasis - severe chronic plaque Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) 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.		
O Patient had "whole body" severe chronic plaque	psoriasis at the start of treatment	
or or is sustained at this level, when co	nt course the patient has a PASI score which is reduced by 75% or ompared with the pre-adalimumab treatment baseline value nt course the patient has a Dermatology Quality of Life Index (DLQI) d with the pre-treatment baseline value	
or		
O Patient had severe chronic plaque psoriasis of th	he face, or palm of a hand or sole of a foot at the start of treatment	
	nt course the patient has a reduction in the PASI symptom subscores g, to slight or better, or sustained at this level, as compared to the	
O Following each prior adalimumab treatmer affected, or sustained at this level, as com	nt course the patient has a reduction of 75% or more in the skin area pared to the pre-adalimumab treatment baseline value	
and O Adalimumab to be administered at doses no greater than 40 mg every 14 days		
INITIATION – Pyoderma gangrenosum Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)		
O Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
O The patient has experienced intolerable side effects fro	om adalimumab (Amgevita) following a minimum of 4 weeks treatment	
O Patient has developed symptoms of loss of disease co (Amgevita) and clinician attributes this loss of disease	ntrol following a minimum of 4 weeks treatment with adalimumab response to a change in treatment regimen	
and O Patient has received a maximum of 6 months treatment with and	Amgevita	
O Patient has previously had a Special Authority approval for the	ne Humira brand of adalimumab for this indication	
A maximum of 8 doses		

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 th	e Pharmaceutical
Schedule. For community funding, see the Special Authority Criteria.			

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Adalimumab (Humira - Alternative brand) - continued	
CONTINUATION – Pyoderma gangrenosum Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a dermatologist, or in accordate Hospital. and O The patient has demonstrated clinical improvement and common of 8 doses	ance with a protocol or guideline that has been endorsed by the Health NZ
INITIATION – Crohn's disease - adult Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a gastroenterologist or Practite protocol or guideline that has been endorsed by the Health NZ Health and	tioner on the recommendation of a gastroenterologist, or in accordance with a ospital.
O The patient has experienced intolerable side effects f and a maximum of 6 months treatment with Amgevita or O Patient has developed symptoms of loss of disease of 6 months treatment with Amgevita and clinician attrib	control following a minimum of 4 weeks treatment, and a maximum of outes this loss of disease response to a change in treatment regimen disease destabilisation if there were to be a change to current treatment the Humira brand of adalimumab for this indication
CONTINUATION – Crohn's disease - adult Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	vioner on the recommendation of a gastroenterologist, or in accordance with a
and protocol or guideline that has been endorsed by the Health NZ He	I score when the patient was initiated on adalimumab e to treatment, but CDAI score cannot be assessed

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:				
Adal	imu	mat	o (Hu	umira - Alternative brand) - continued
Re-a	ssess	smen	nt requ	a's disease - children uired after 6 months boxes where appropriate)
Prero				
and				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 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
		or	0	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
			Ο	Patient has Crohn's and is considered to be at risk of disease destabilisation if there were to be a change to current treatment
	and and	Ο	Patie	ent has previously had a Special Authority approval for the Humira brand of adalimumab for this indication
		Ο	Adali	imumab to be administered at doses no greater than 40 mg every 14 days
	equis F	ites Prese	(tick k cribed	uired after 6 months boxes 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. 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
	and	0	Adali	imumab 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)				
and				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 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
		or	0	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
	لمعم		\bigcirc	Patient has Crohn's and is considered to be at risk of disease destabilisation if there were to be a change to current treatment
	and O Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication and			
		Ο	Adali	imumab to be administered at doses no greater than 40 mg 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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Adalimumab (Humira - Alternative brand) - continued	
CONTINUATION – Crohn's disease - fistulising Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a gastroenterologist or Practition protocol or guideline that has been endorsed by the Health NZ Hosp and	er on the recommendation of a gastroenterologist, or in accordance with a ital.
O The number of open draining fistulae have decreased from O There has been a marked reduction in drainage of all fis Assessment score, together with less induration and pate and O Adalimumab to be administered at doses no greater than 40 m	tula(e) from baseline as demonstrated by a reduction in the Fistula tient-reported pain
INITIATION – Ocular inflammation – chronic Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in ac NZ Hospital.	cordance with a protocol or guideline that has been endorsed by the Health
O The patient has experienced intolerable side effects from and a maximum of 6 months treatment with Amgevita O Patient has developed symptoms of loss of disease com	Humira brand of adalimumab for this indication
CONTINUATION – Ocular inflammation – chronic Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in ac NZ Hospital.	cordance with a protocol or guideline that has been endorsed by the Health
O The patient has had a good clinical response following 1 or O 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 as a sustained steroid sparing effect, allowing reduction in prednisone under 18 years old

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:	
Adalimumab (Humira - Alternative brand) - continued		
INITIATION – Ocular inflammation – severe Re-assessment required after 12 months		
Prerequisites (tick boxes where appropriate)		
O Prescribed by, or recommended by any relevant practitioner, or in an NZ Hospital.	ccordance with a protocol or guideline that has been endorsed by the Health	
O The patient has experienced intolerable side effects from and a maximum of 6 months treatment with Amgevita	n adalimumab (Amgevita) following a minimum of 4 weeks treatment,	
	trol following a minimum of 4 weeks treatment with Amgevita, and a nician attributes this loss of disease response to a change in treatment	
O Patient has uveitis and is considered to be at risk of visi	on loss if they were to change treatment	
and O Patient has previously had a Special Authority approval for the and	Humira brand of adalimumab for this indication	
Adalimumab to be administered at doses no greater than 40 r	ng every 14 days	
NZ Hospital.	ccordance with a protocol or guideline that has been endorsed by the Health	
and O The patient has had a good clinical response following a	3 initial doses	
O Following each 12-month treatment period, the patient I Uveitis Nomenclature (SUN) criteria < ½+ anterior char resolution of uveitic cystoid macular oedema)	has had a sustained reduction in inflammation (Standardisation of the or vitreous cells, absence of active vitreous or retinal lesions, or	
or Following each 12-month treatment period, the patient I to < 10mg daily, or steroid drops less than twice daily if	nas a sustained steroid sparing effect, allowing reduction in prednisone under 18 years old	
Adalimumab to be administered at doses no greater than 40 mg every 14 days		

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:	
Adalimumab (Humira - Alternative brand) - continued		
INITIATION – ankylosing spondylitis Re-assessment required after 6 months		
Prerequisites (tick boxes where appropriate)		
O Prescribed by, or recommended by a rheumatologist or Practitioner protocol or guideline that has been endorsed by the Health NZ Hos	on the recommendation of a rheumatologist, or in accordance with a pital.	
or	m adalimumab (Amgevita) following a minimum of 4 weeks treatment	
(Amgevita)	trol following a minimum of 4 weeks treatment with adalimumab	
and O Patient has received a maximum of 6 months treatment with <i>i</i> and	Amgevita	
O Patient has previously had a Special Authority approval for the	e Humira brand of adalimumab for this indication	
Adalimumab to be administered at doses no greater than 40 r	ng every 14 days	
Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a rheumatologist or Practitioner protocol or guideline that has been endorsed by the Health NZ Hos and	on the recommendation of a rheumatologist, or in accordance with a pital.	
O 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	
Adalimumab to be administered at doses no greater than 40 r	ng every 14 days	
INITIATION – Arthritis – oligoarticular course juvenile idiopathic Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)		
O Prescribed by, or recommended by a named specialist or rheumato by the Health NZ Hospital.	logist, or in accordance with a protocol or guideline that has been endorsed	
or	m adalimumab (Amgevita) following a minimum of 4 weeks treatment htrol following a minimum of 4 weeks treatment with adalimumab	
(Amgevita) and clinician attributes this loss of disease r and O Patient has received a maximum of 6 months treatment with A	esponse to a change in treatment regimen	
and O Patient has previously had a Special Authority approval for the		

Form RS1922 March 2025	HOSPITAL MEDICINES LIST Page 4 RESTRICTIONS CHECKLIST	
Use this checklist to determine if a patient meets the restric Schedule. For community funding, see the Special Authori	tions for funding in the hospital setting . For more details, refer to Section H of the Pharmaceutical ty Criteria.	
PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Adalimumab (Humira - Alternative brand) - a	continued	
CONTINUATION – Arthritis – oligoarticular course juv Re-assessment required after 6 months Prerequisites (tick box where appropriate)	enile idiopathic	
by the Health NZ Hospital.	ecialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed ing 30% improvement 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 rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
O Patient has developed symptoms of	able side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment f loss of disease control following a minimum of 4 weeks treatment with adalimumab his loss of disease response to a change in treatment regimen	
	ority approval for the Humira brand of adalimumab for this indication	
by the Health NZ Hospital.	ecialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed ing 30% improvement 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)

and				by, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed Ith NZ Hospital.
		or	0	The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment
			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			
		Ο	Patie	nt has received a maximum of 6 months treatment with Amgevita
	and			······································
		\bigcirc	Patie	nt has previously had a Special Authority approval for the Humira brand of adalimumab for this indication
	and	0	Adali	mumab to be administered at doses no greater than 40 mg 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.

PRESCRIBER	PATIENT:	
Name: Name:		
Ward: NHI:		
Adalimumab (Humira - Alternative brand) - continued		
CONTINUATION – Arthritis - psoriatic Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)		
by the Health NZ Hospital.	ologist, or in accordance with a protocol or guideline that has been endorsed	
O The patient demonstrates at least a continuing 30% improver response to prior adalimumab treatment in the opinion of the and	nent in active joint count from baseline and a clinically significant treating physician	
O 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)		
O Prescribed by, or recommended by a rheumatologist or Practitioner protocol or guideline that has been endorsed by the Health NZ Hos	on the recommendation of a rheumatologist, or in accordance with a pital.	
or	m adalimumab (Amgevita) following a minimum of 4 weeks treatment ntrol following a minimum of 4 weeks treatment with adalimumab response to a change in treatment regimen	
and O Patient has received a maximum of 6 months treatment with and	Amgevita	
O Patient has previously had a Special Authority approval for th	e Humira brand of adalimumab for this indication	
O Adalimumab to be administered at doses no greater the	an 40 mg every 14 days	
O Patient cannot take concomitant methotrexate and requant an adequate response	ires doses of adalimumab higher than 40 mg every 14 days to maintain	
CONTINUATION – Arthritis – rheumatoid Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)		
O Prescribed by, or recommended by a rheumatologist or Practitioner protocol or guideline that has been endorsed by the Health NZ Hos	on the recommendation of a rheumatologist, or in accordance with a pital.	
O The patient demonstrates at least a continuing 30% improver response to prior adalimumab treatment in the opinion of the and	nent in active joint count from baseline and a clinically significant treating physician	
or O Adalimumab to be administered at doses no greater that O Patient cannot take concomitant methotrexate and require an adequate response	an 40 mg every 14 days uires doses of adalimumab 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)			
	on the recommendation of a rheumatologist, or in accordance with a bital.		
or o	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		
and O Patient has received a maximum of 6 months treatment with Amgevita and O Patient has previously had a Special Authority approval for the 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)

and

rerequiences (liek box 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.

The patient has demonstrated a sustained improvement in inflammatory markers and functional status

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	e:		Name:
Ward:			NHI:
Abci	xin	nab	
INITI Prere		ON isites (tick boxes where appropriate)	
	or	O For use in patients with acute coronary syndromes undergoing	percutaneous coronary intervention
	or	O For use in patients undergoing intra-cranial intervention	
\sim			

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:			
livolumab				

Re-as	sessr	nt required after 4 months	
		s (tick boxes where appropriate)	
and		scribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health pital.	n NZ
	(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	
		O Patient has not received funded pembrolizumab	
		O 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	
;	and O Documentation confirming that the patient has been informed and acknowledges that funded treatment with nivolumab will not be continued if their disease progresses		
Prerec	quisit	nt required after 4 months s (tick boxes where appropriate) scribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health pital.	h NZ
and	(
		O Patient's disease has had a complete response to treatment or	
		O Patient's disease has had a partial response to treatment or _	
		O Patient has stable disease	
		Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period	
		nd O The treatment remains clinically appropriate and the patient is benefitting from the treatment	
	or	\sim	
	or	O The treatment remains clinically appropriate and the patient is benefitting from the treatment O Patient has previously discontinued treatment with nivolumab for reasons other than severe toxicity or disease progression	
	or	O The treatment remains clinically appropriate and the patient is benefitting from the 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 Pharmaceutica
Schedule. For community funding, see the Special Authority Criteria.

PRESCRIBER	PATIENT:	
lame: Name:		
Ward:	NHI:	
Nivolumab - continued		
CONTINUATION – more than 24 months on treatment Re-assessment required after 4 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a medical oncologist, or in accord Hospital. and	rdance with a protocol or guideline that has been endorsed by the Health NZ	
A Patient has been on treatment for more than 24 months		
the most recent treatment period and The treatment remains clinically appropriate and or	e to treatment Indetermined by comparable radiologic or clinical assessment following the patient is benefitting from the treatment h nivolumab for reasons other than severe toxicity or disease	
	vant practitioner on the recommendation of a relevant specialist, or in	
and and O Patient is currently on treatment with nivolumab and met all re- or O Patient has metastatic renal-cell carcinoma		

	Patient has metastatic renal-cell carcinoma
and	The disease is of predominant clear-cell histology
and	Patient has an ECOG performance score of 0-2
and	Patient has documented disease progression following one or two previous regimens of antiangiogenic therapy
and	Nivolumab is to be used as monotherapy at a maximum dose of 240 mg every 2 weeks (or equivalent) and discontinued at 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.

PRES	SCRIBE	R		PATIENT:
Name	:			Name:
Ward	:			NHI:
Nivo	lumab) - co	ntinued	
Re-a	ssessm	ent re	- Renal cell carcinoma quired after 4 months k boxes where appropriate)	
(and		escrib Hosp		cordance with a protocol or guideline that has been endorsed by the Health
		C	D Patient's disease has had a complete response to treatm	nent
		or C) Patient's disease has had a partial response to treatmen	t
		or C	D Patient has stable disease	
	and) No	evidence of disease progression	
	C		volumab is to be used as monotherapy at a maximum dose ogression	of 240 mg every 2 weeks (or equivalent) and discontinued at disease

RS2056 - Pembrolizumab

MSI-H/dMMR advanced colorectal cancer - INITIATION	
MSI-H/dMMR advanced colorectal cancer - CONTINUATION	
Urothelial carcinoma - INITIATION	
Urothelial carcinoma - CONTINUATION	
Breast cancer, advanced - INITIATION	
Breast cancer, advanced - CONTINUATION	
Head and neck squamous cell carcinoma - INITIATION	
Head and neck squamous cell carcinoma - CONTINUATION	
Non-small cell lung cancer first-line combination therapy - INITIATION	
Non-small cell lung cancer first-line combination therapy - CONTINUATION	
Non-small cell lung cancer first-line monotherapy - INITIATION	
Non-small cell lung cancer first-line monotherapy - CONTINUATION	
Relapsed/refractory Hodgkin lymphoma - INITIATION	
Relapsed/refractory Hodgkin lymphoma - CONTINUATION Unresectable or metastatic melanoma - INITIATION	
Unresectable or metastatic melanoma - INITIATION	
Unresectable or metastatic melanoma, more than 24 months on treatment - CONTINUATION	
onresectable of metastatic metanoma, more trian 24 months on treatment - CON HNOATION .	

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:	

Pembrolizumab

INITIATION – unresectable or metastatic melanoma					
Re-assessment required after 4 months					
Prerequisites (tick boxes where appropriate)					
	\cap	_			
			ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ		
		Hosp	tal.		
and					
		\bigcirc	Patient has metastatic or unresectable melanoma (excluding uveal) stage III or IV		
	and	1			
			Baseline measurement of overall tumour burden is documented clinically and radiologically		
	and	۰ ۱	Baseline measurement of overall turnour burden is documented clinically and radiologically		
	une		The patient has ECOG performance score of 0-2		
	one		The patient has ECOG performance score of 0-2		
	and	۔ ۲			
			O Patient has not received funded nivolumab		
		or			
			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	1			
		\bigcirc	Documentation confirming that the patient has been informed and acknowledges that funded treatment with pembrolizumab will not be		
			continued if their disease progresses		
			N – unresectable or metastatic melanoma, less than 24 months on treatment		
			N – unresectable or metastatic melanoma, less than 24 months on treatment required after 4 months		
Re-a	asses	smen			
Re-a	asses	smen	required after 4 months		
Re-a	asses r equi :	smen sites	required after 4 months		
Re-a	asses r equi :	smen sites	required after 4 months (tick boxes where appropriate) ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ		
Re-a	asses requi	smen sites Presc	required after 4 months (tick boxes where appropriate) ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ		
Re-a Prei	asses requi	smen sites Presc	required after 4 months (tick boxes where appropriate) ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ		
Re-a Prei	asses requi	smen sites Presc	ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal.		
Re-a Prei	asses requi	smen sites Presc	required after 4 months (tick boxes where appropriate) ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal.		
Re-a Prei	asses requi	smen sites Presc	required after 4 months (tick boxes where appropriate) ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal.		
Re-a Prei	asses requi	smen sites Presc	required after 4 months (tick boxes where appropriate) ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal.		
Re-a Prei	asses requi	smen sites Presc	required after 4 months (tick boxes where appropriate) ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal.		
Re-a Prei	asses requi	smen sites Presc	required after 4 months (tick boxes where appropriate) ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal.		
Re-a Prei	asses requi	ssmen sites Presc Hosp	required after 4 months (tick boxes where appropriate) ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal.		
Re-a Prei	asses requi	smen sites Presc	required after 4 months (tick boxes where appropriate) ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal.		
Re-a Prei	asses requi	ssmen sites Presc Hosp	required after 4 months (tick boxes where appropriate) ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal.		
Re-a Prei	asses requi	ssmen sites Presc Hosp	irrequired after 4 months (tick boxes where appropriate) ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal. O Patient's disease has had a complete response to treatment or O Patient's disease has had a partial response to treatment or O Patient's disease has had a partial response to treatment or O Patient has stable disease O Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period		
Re-a Prei	asses requi	ssmen sites Presc Hosp	 required after 4 months (tick boxes where appropriate) ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal. O Patient's disease has had a complete response to treatment or O Patient's disease has had a partial response to treatment or O Patient's disease has had a partial response to treatment or O Patient has stable disease O Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period 		
Re-a Prei	asses requi	ssmen sites Presc Hosp	irrequired after 4 months (tick boxes where appropriate) ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal. O Patient's disease has had a complete response to treatment or O Patient's disease has had a partial response to treatment or O Patient's disease has had a partial response to treatment or O Patient has stable disease O Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period		
Re-a Prei	O	ssmen sites Presc Hosp	 required after 4 months (tick boxes where appropriate) ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal. O Patient's disease has had a complete response to treatment or O Patient's disease has had a partial response to treatment or O Patient's disease has had a partial response to treatment or O Patient has stable disease O Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period 		
Re-a Prei	asses requi	ssmen sites Presc Hosp	 required after 4 months (tick boxes where appropriate) ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal. O Patient's disease has had a complete response to treatment or O Patient's disease has had a partial response to treatment or O Patient's disease has had a partial response to treatment or O Patient has stable disease O Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period 		
Re-a Prei	O	ssmen sites Presc Hosp	 required after 4 months (tick boxes where appropriate) ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal. O Patient's disease has had a complete response to treatment O Patient's disease has had a partial response to treatment O Patient's disease has had a partial response to treatment O Patient has stable disease O Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period O The treatment remains clinically appropriate and the patient is benefitting from the treatment 		
Re-a Prei	O	ssmen sites Presc Hosp	 required after 4 months (tick boxes where appropriate) ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal. O Patient's disease has had a complete response to treatment or O Patient's disease has had a partial response to treatment or O Patient's disease has had a partial response to treatment or O Patient has stable disease A Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period O The treatment remains clinically appropriate and the patient is benefitting from the treatment O Patient has previously discontinued treatment with pembrolizumab for reasons other than severe toxicity or disease progression 		
Re-a Prei	O	smen sites Presc Hosp and and	 required after 4 months (tick boxes where appropriate) ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal. O Patient's disease has had a complete response to treatment or O Patient's disease has had a partial response to treatment or O Patient has stable disease O Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period O The treatment remains clinically appropriate and the patient is benefitting from the treatment O Patient has previously discontinued treatment with pembrolizumab for reasons other than severe toxicity or disease progression 		
Re-a Prei	O	and and and	 ir required after 4 months (tick boxes where appropriate) ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal. O Patient's disease has had a complete response to treatment or O Patient's disease has had a partial response to treatment or O Patient has stable disease O Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period O The treatment remains clinically appropriate and the patient is benefitting from the treatment O Patient has previously discontinued treatment with pembrolizumab for reasons other than severe toxicity or disease progression O Patient has signs of disease progression 		
Re-a Prei	O	smen sites Presc Hosp and and	 required after 4 months tick boxes where appropriate) ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal. 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 O Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period O The treatment remains clinically appropriate and the patient is benefitting from the treatment O Patient has previously discontinued treatment with pembrolizumab for reasons other than severe toxicity or disease progression O Patient has signs of disease progression 		
Re-a Prei	O	and and and	 ir required after 4 months (tick boxes where appropriate) ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal. O Patient's disease has had a complete response to treatment or O Patient's disease has had a partial response to treatment or O Patient has stable disease O Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period O The treatment remains clinically appropriate and the patient is benefitting from the treatment O Patient has previously discontinued treatment with pembrolizumab for reasons other than severe toxicity or disease progression O 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.			
PRESCRIB	ER		PATIENT:
Name:			Name:
Ward:			NHI:
Pembroli	zum	ab - con	tinued
Re-assess Prerequisi	ment i ites (ti Prescri lospita	required a ck boxes bed by, or al.	 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 or clinical 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
		and	Progression Patient has signs of disease progression

Disease has not progressed during previous treatment with pembrolizumab

I confirm that the above details are correct:

and

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:
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 relevance with a protocol or guideline that has been endorsed by the and	vant practitioner on the recommendation of a medical oncologist, or in the Health NZ Hospital.
O Patient has locally advanced or metastatic, unresectable, non	-small cell lung cancer
O Patient has not had chemotherapy for their disease in the pall	iative setting
O Patient has not received prior funded treatment with an immur	ne checkpoint inhibitor for NSCLC
EGFR or ALK tyrosine kinase unless not possible to ascertain	tion confirming that the disease does not express activating mutations of
and O Pembrolizumab to be used as monotherapy and	
O There is documentation confirming the disease express validated test unless not possible to ascertain	es PD-L1 at a level greater than or equal to 50% as determined by a
O There is documentation confirming the disease ex by a validated test unless not possible to ascertain	presses PD-L1 at a level greater than or equal to 1% as determined
	interest of the patient based on clinician assessment
and O Patient has an ECOG 0-2	
O Pembrolizumab to be used at a maximum dose of 200 mg eve	ery three weeks (or equivalent) for a maximum of 16 weeks
Baseline measurement of overall tumour burden is documente	ed clinically and radiologically

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:	Vard: NHI:		
Pem	brolizu	Imab - continued	
Re-a	ssessme	ION – non-small cell lung cancer first-line monotherapy ent required after 4 months s (tick boxes where appropriate)	
(and		scribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in ordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	
		O Patient's disease has had a complete response to treatment	
	o	Patient's disease has had a partial response to treatment Patient has stable disease	
	and	Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period	
	and and	No evidence of disease progression	
	and	The treatment remains clinically appropriate and patient is benefitting from treatment	
	and	Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent)	
	0	Treatment with pembrolizumab to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks)	
Re-a	ssessme	ent required after 4 months s (tick boxes where appropriate)	
(and		scribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in ordance 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	
	and	The patient has not had chemotherapy for their disease in the palliative setting	
	and	Patient has not received prior funded treatment with an immune checkpoint inhibitor for NSCLC	
	and	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	
	0	Pembrolizumab to be used in combination with platinum-based chemotherapy	
	and and	Patient has an ECOG 0-2	
	0	Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent) for a maximum of 16 weeks	
	and	Baseline measurement of overall tumour burden is documented clinically and radiologically	

	BER	PATIENT:		
ie:		Name:		
d:		NHI:		
nbrol	lizun	Imab - continued		
assess requis	sment sites (ION – non-small cell lung cancer first-line combination therapy ent required after 4 months s (tick boxes where appropriate)		
		scribed by, or recommended by a medical oncologist or any relevant practitioner on the record ordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	ommendation of a medical oncologist, or in	
	or	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		
and	0	Response to treatment in target lesions has been determined by comparable radiologic a treatment period	ssessment following the most recent	
and	Ο	No evidence of disease progression		
and	Ο	The treatment remains clinically appropriate and patient is benefitting from treatment		
and	-	Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivale	ent)	
	()			
		Treatment with pembrolizumab to cease after a total duration of 24 months from commer every 3 weeks)	ncement (or equivalent of 35 cycles dosed	
		every 3 weeks)	ncement (or equivalent of 35 cycles dosed	
assess	DN – b sment	every 3 weeks) breast cancer, advanced ent required after 6 months	ncement (or equivalent of 35 cycles dosed	
assess requis	DN – b sment sites (every 3 weeks) breast cancer, advanced ent required after 6 months s (tick boxes where appropriate)		
assess requis	DN – b sment sites (Presc	every 3 weeks) breast cancer, advanced ent required after 6 months		
assess requis	DN – b sment sites (Presc accore	every 3 weeks) breast cancer, advanced ent required after 6 months s (tick boxes where appropriate) scribed by, or recommended by a relevant specialist or any relevant practitioner on the reco	mmendation of a relevant specialist, or in	
	DN – b sment sites (Presc accore	every 3 weeks)	mmendation of a relevant specialist, or in to commencing treatment riple-negative breast cancer (that does not	
	DN – b sment sites (Presc accore	every 3 weeks)	mmendation of a relevant specialist, or in to commencing treatment riple-negative breast cancer (that does not r])	
	DN – b sment sites (Presc accore	every 3 weeks)	mmendation of a relevant specialist, or in to commencing treatment riple-negative breast cancer (that does not r])	
	DN – b ssment sites (Presc accord	every 3 weeks)	mmendation of a relevant specialist, or in o commencing treatment riple-negative breast cancer (that does not ']) tt does not express ER, PR or HER2 IHC3+	
	DN – b ssment sites (Presc accord	every 3 weeks)	mmendation of a relevant specialist, or in o commencing treatment riple-negative breast cancer (that does not ']) tt does not express ER, PR or HER2 IHC3+	
	DN – b ssment sites (Presc accord O	every 3 weeks)	mmendation of a relevant specialist, or in o commencing treatment riple-negative breast cancer (that does not ']) tt does not express ER, PR or HER2 IHC3+	
	DN – b ssment sites (Presc accord O and and and	every 3 weeks)	mmendation of a relevant specialist, or in o commencing treatment riple-negative breast cancer (that does not []) It does not express ER, PR or HER2 IHC3+	
	DN – b ssment sites (Presc accord O and and and and	every 3 weeks)	mmendation of a relevant specialist, or in o commencing treatment riple-negative breast cancer (that does not 1) It does not express ER, PR or HER2 IHC3+	

Signed:	d: Date:	
olgricu.	d 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:	
Ward:	NHI:
Pembrolizu	mab - continued
Re-assessmer Prerequisites O Prese	DN – breast cancer, advanced ht 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.
or	O Patient's disease has had a partial response to treatment
and and and and and	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) 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-assessmer Prerequisites O Prese	head and neck squamous cell carcinoma ht 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 rdance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
or an an an an an	 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

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	:						
Pem	Pembrolizumab - continued						
Re-a	DNTINUATION – head and neck squamous cell carcinoma -assessment required after 4 months erequisites (tick boxes where appropriate) O 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. d						
	and (and (and	or or O	Pemb Treat	Patient's disease has had a complete response to treatment Patient's disease has had a partial response to treatment Patient has stable disease vidence of disease progression prolizumab is to be used at a maximum dose of 200 mg every three weeks (or equivalent) ment with pembrolizumab is to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed (3 weeks)			
Re-a	TIATION – MSI-H/dMMR advanced colorectal cancer assessment required after 4 months requisites (tick boxes where appropriate) O 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	and and and and and		 Patient has deficient mismatch repair (dMMR) or microsatellite instability-high (MSI-H) metastatic colorectal cancer Patient has deficient mismatch repair (dMMR) or microsatellite instability-high (MSI-H) unresectable colorectal cancer 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 Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent) for a maximum of 16 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.	

PRESC	BER PATIENT:
Name:	Name:
Ward: .	NHI:
Pembr	lizumab - continued
Re-ass	JATION – MSI-H/dMMR advanced colorectal cancer sment required after 4 months sites (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.
and	 No evidence of disease progression Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent)
Re-ass	DN – Urothelial carcinoma sment required after 4 months sites (tick boxes where appropriate) Prescribed by, or recommended by a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in
and	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 O Patient has inoperable locally advanced (T4) or metastatic urothelial carcinoma and O Patient has an ECOG performance score of 0-2
	and O Patient has documented disease progression following treatment with chemotherapy and O 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-ass	JATION – Urothelial carcinoma sment required after 4 months sites (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.
a	 No evidence of disease progression Pembrolizumab is to be used as monotherapy at a maximum dose of 200 mg every three weeks (or equivalent)

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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:		

Pembrolizumab - continued

()

Re-asse	ssment	elapsed/refractory Hodgkin lymphoma required after 4 months tick boxes where appropriate)
O and	accord	ibed by, or recommended by a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in Jance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
or	and	 O Patient has relapsed/refractory Hodgkin lymphoma after two or more lines of chemotherapy and O Patient is ineligible for autologous stem cell transplant or O Patient has relapsed/refractory Hodgkin lymphoma and has previously undergone an autologous stem cell transplant O Patient has not previously received funded pembrolizumab
Re-asse	ssment I isites (t	N – relapsed/refractory Hodgkin lymphoma required after 6 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 aspital.
and		Patient has received a partial or complete response to pembrolizumab

Treatment with pembrolizumab is to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 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:	Name:		
Ward:	NHI:		
Durvalumab			

	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	О	Patient has received two or more cycles of platinum-based chemotherapy concurrently with definitive radiation therapy
anu (О	Patient has no disease progression following the second or subsequent cycle of platinum-based chemotherapy with definitive radiatic therapy treatment
and (О	Patient has a ECOG performance status of 0 or 1
and (and	О	Patient has completed last radiation dose within 8 weeks of starting treatment with durvalumab
and (Ο	Patient must not have received prior PD-1 or PD-L1 inhibitor therapy for this condition
	or	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
and	$\overline{\mathbf{O}}$	Treatment with durvalumab to cease upon signs of disease progression

Re-assessment required after 4 months **Prerequisites** (tick boxes where appropriate)

cquisi	1103	(lick boxes where appropriate)
໌ and	С	The treatment remains clinically appropriate and the patient is benefitting from treatment
and		O Durvalumab is to be used at a maximum dose of no greater than 10 mg/kg every 2 weeks
	or	O Durvalumab is to be used at a flat dose of 1500 mg every 4 weeks
and (and	С	Treatment with durvalumab to cease upon signs of disease progression
(С	Total continuous treatment duration must not exceed 12 months

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	ame: Name:				
Ward	/ard:				
Atez	olizuma	ab			
Re-a	ssessmer equisites O Prese	non-small cell lung cancer second line monotherapy th 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 rdance 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 Patient has not received prior funded treatment with an immune checkpoint inhibitor for NSCLC Por 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 				
Re-a	ssessmer equisites O Prese	DN – non-small cell lung cancer second line monotherapy ht 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 rdance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
	and and and and and and and	O Patient's disease has had a partial response to 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:		

Atezolizumab - continued

or	O F	Patie	ent is currently on treatment with atezolizumab and met all remaining criteria prior to commencing treatment
	and	Ο	Patient has locally advanced or metastatic, unresectable hepatocellular carcinoma
		Ο	Patient has preserved liver function (Child-Pugh A)
	and	Ο	Transarterial chemoembolisation (TACE) is unsuitable
	and	\square	
		or	O Patient has not received prior systemic therapy for the treatment of hepatocellular carcinoma
		or	O Patient received funded lenvatinib before 1 March 2025
			O Patient has experienced treatment-limiting toxicity from treatment with lenvatinib
			and
			O No disease progression since initiation of lenvatinib
	and	\bigcirc	Patient has an ECOG performance status of 0-2
	and	\sim	
		\bigcirc	To be given in combination with bevacizumab

Prerequisites (tick box where appropriate)

O No evidence 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.

PRES	CRIB	ER PATIENT:			
Name:	ame: Name:				
Ward:	Nard: NHI:				
Evero	olim	us			
Prere (and	sessi quisi	 I ment required after 3 months tes (tick boxes where appropriate) rescribed by, or recommended by a neurologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by the ealth NZ Hospital. O Patient has tuberous sclerosis O Patient has progressively enlarging sub-ependymal giant cell astrocytomas (SEGAs) that require treatment 			
	isessi i quisi D P	ATION ment required after 12 months tes (tick boxes where appropriate) rescribed by, or recommended by a neurologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by the ealth NZ Hospital.			
	and (and	 Documented evidence of SEGA reduction or stabilisation by MRI within the last 3 months The treatment remains appropriate and the patient is benefiting from treatment Everolimus to be discontinued at progression of SEGAs 			
Re-as	sessi	I – renal cell carcinoma nent required after 4 months tes (tick boxes where appropriate)			
		 The patient has metastatic renal cell carcinoma The disease is of predominant clear-cell histology The patient has documented disease progression following one previous line of treatment The patient has an ECOG performance status of 0-2 Everolimus is to be used in combination with lenvatinib 			
	or	 Patient has received funded treatment with nivolumab for the second line treatment of metastatic renal cell carcinoma Patient has experienced treatment limiting toxicity from treatment with nivolumab Patient has experienced treatment limiting toxicity from treatment with nivolumab Everolimus is to be used in combination with lenvatinib There is no evidence of disease progression 			
Re-as	sessi	ATION – renal cell carcinoma nent required after 4 months tes (tick box where appropriate)			
	Эт	here is no evidence of disease progression			

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 th	e Pharmaceutical
Schedule. For community funding, see the Special Authority Criteria.			

		PATIENT:
e:		Name:
d:		NHI:
olimus		
TIATION		
requisites	(tick box where appropriate)	
e: Rescue t	escue therapy for an organ transplant recipient therapy defined as unresponsive to calcineurin inhibitor trea o any of the following:	tment as defined by refractory rejection; or intolerant to calcineurin inhibitor
GFR < 30 m	nl/min; or	
Rapidly pro	gressive transplant vasculopathy; or	
Rapidly proo	gressive obstructive bronchiolitis; or	
HUS or TTF	; or	
∟eukoencep	othalopathy; or	
Significant n	nalignant disease	
or or	 Malformations are not adequately controlled by sclere Malformations are widespread/extensive and sclerot Sirolimus is to be used to reduce malformation prior 	herapy and surgery are not considered clinically appropriate
and O and O	Patient is being treated by a specialist lymphovascular mal Patient has measurable disease as defined by RECIST ve	formation multi-disciplinary team
And O NTINUATIO assessment		formation multi-disciplinary team rsion 1.1 (see Note)
And O NTINUATIO assessment	Patient has measurable disease as defined by RECIST vertices of the severe non-malignant lymphovascular malformatics trequired after 12 months (tick boxes where appropriate) O Patient's disease has had either a complete response according to RECIST version 1.1 (see Note) O Patient's disease has stabilised or responded clinical	formation multi-disciplinary team rsion 1.1 (see Note)
NTINUATIO assessment requisites	Patient has measurable disease as defined by RECIST version N – severe non-malignant lymphovascular malformatic trequired after 12 months (tick boxes where appropriate) O Patient's disease has had either a complete response according to RECIST version 1.1 (see Note)	formation multi-disciplinary team rsion 1.1 (see Note)
O and NTINUATIO assessment requisites	Patient has measurable disease as defined by RECIST vertices of the severe non-malignant lymphovascular malformatics trequired after 12 months (tick boxes where appropriate) O Patient's disease has had either a complete response according to RECIST version 1.1 (see Note) O Patient's disease has stabilised or responded clinical	formation multi-disciplinary team rsion 1.1 (see Note)

1.1 (Eisenhauer et al. Eur J Cancer 2009;45:228-47) Indications marked with * are unapproved indications

	ermine if a patient meets the restrictions for funding in the hospital setting . For more details, refer to Section H of the Pharmaceutica by funding, see the Special Authority Criteria.
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Sirolimus - continue	d
Re-assessment require Prerequisites (tick box	es where appropriate) , or recommended by a nephrologist or urologist, or in accordance with a protocol or guideline that has been endorsed by the
and O Patient	has tuberous sclerosis complex*
and O Evidence	ce of renal angiomyolipoma(s) measuring 3 cm or greater and that have shown interval growth
CONTINUATION – ren Re-assessment require Prerequisites (tick box	
O Docum	ented evidence of renal angiomyolipoma reduction or stability by magnetic resonance imaging (MRI) or ultrasound
O Demon	strated stabilisation or improvement in renal function
and O The pai and	ient has not experienced angiomyolipoma haemorrhage or significant adverse effects to sirolimus treatment
O The tre	atment remains appropriate and the patient is benefitting from treatment
Note: Indications mark	ed with * are unapproved indications
Re-assessment require Prerequisites (tick box	
and O Patient	has epilepsy with a background of documented tuberous sclerosis complex*
and (and (Vigabatrin has been trialled and has not adequately controlled seizures Seizures are not adequately controlled by, or the patient has experienced unacceptable side effects from, optimal treatment with at least two of the following: sodium valproate, topiramate, levetiracetam, carbamazepine, lamotrigine, phenytoin sodium, and lacosamide (see Note)
or ((and	 Vigabatrin is contraindicated Seizures are not adequately controlled by, or the patient has experienced unacceptable side effects from, optimal treatment with at least three of the following: sodium valproate, topiramate, levetiracetam, carbamazepine, lamotrigine, phenytoin sodium, and lacosamide (see Note)
and O Patient benefit	s have a significant impact on quality of life has been assessed and surgery is considered inappropriate for this patient, or the patient has been assessed and would from mTOR inhibitor treatment prior to surgery aring potential are not required to trial phenytoin sodium, sodium valproate, and topiramate. Those who can father children are not

 \bigcirc

and

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:	
Sirolimus - continued		
CONTINUATION – refractory seizures associated with tuberous sclerosis complex*		

Re-assessment required after 12 months Prerequisites (tick box where appropriate)

> Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

Demonstrated significant and sustained improvement in seizure rate (e.g. 50% reduction in seizure frequency) or severity and/or patient quality of life compared with baseline prior to starting sirolimus 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:
Bacillus calmette-guerin (BCG)	
INITIATION Prerequisites (tick box where appropriate)	
O For use in bladder cancer	

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:

Upadacitinib

Re-a	INITIATION – Rheumatoid Arthritis (patients previously treated with adalimumab or etanercept) Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)				
and			rescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ospital.		
	and	0	The p	atient has had an initial Special Authority approval for adalimumab and/or etanercept for rheumatoid arthritis	
		O The patient has experienced intolerable side effects from adalimumab and/or etanercept or O 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			
	and	or O The patient is seronegative for both anti-cyclic citrullinated peptide (CCP) antibodies and rheumatoid factor O The patient has been started on rituximab for rheumatoid arthritis in a Health NZ Hospital			
	and O The patient has experienced intolerable side effects from rituximab or O 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				

CONTINUATION – Rheumatoid Arthritis

Re-assessment required after 6 months **Prerequisites** (tick boxes where appropriate)

()

or

rerequisites (lick boxes where appropriate)

C	Prescribed by, or recommended by a rh	neumatologist, or	in accordance with	a protocol or guideline that	has been endorsed by the Health NZ
	Hospital.				
and					

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 from baseline and a clinically significant response to treatment in the opinion of the physician

Respiratory System and Allergies

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	e:			Name:
Ward	:			NHI:
Icati	bar	nt		
	sse	ssmen isites Preso	t required after 12 months (tick boxes where appropriate) cribed by, or recommended by a clinical immunologist or relevar rsed by the Health NZ Hospital.	nt specialist, or in accordance with a protocol or guideline that has been
	an	 Supply for anticipated emergency treatment of laryngeal/oro-pharyngeal or severe abdominal attacks of acute hereditary angioedema (HAE) for patients with confirmed diagnosis of C1-esterase inhibitor deficiency The patient has undergone product training and has agreed upon an action plan for self-administration 		

CONTINUATION

Re-assessment required after 12 months Prerequisites (tick box where appropriate)

O The treatment remains appropriate and the patient is benefiting from treatment

or

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:
Adrenaline	
INITIATION – anaphylaxis Prerequisites (tick boxes where appropriate)	
O Patient has experienced a previous anaphylactic reaction which	ch has resulted in presentation to a hospital or emergency department

Patient has been assessed to be at significant risk of anaphylaxis by a relevant practitioner

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):		Name:
Ward:			NHI:
Bee	venom		
	ATION equisites (t	ick boxes where appropriate)	
	O F	RAST or skin test positive	
	\cap	Patient has had severe generalised reaction to the sensitising	agent

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	:		Name:
Ward:			NHI:
Pape	er wasp	venom	
	ATION equisites	(tick boxes where appropriate)	
	and	RAST or skin test positive	
	0	Patient has had severe generalised reaction to the sensitising	agent

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	PRESCRIBER PATIENT:				
Name: .		Name:			
Ward:		NHI:			
Yellow	jacket wasp venom				
INITIATI Prerequ	ON iisites (tick boxes where appropriate)				
ar	O RAST or skin test positive				
	O Patient has had severe generalised reaction to the sensitising	agent			

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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:		

Long-acting muscarinic antagonists with long-acting beta-adrenoceptor agonists

INITIATION Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)	
O Patient has been stabilised on a long acting muscarinic antagonist and O The prescriber considers that the patient would receive additional benefit from switching	ng to a combination product
CONTINUATION Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)	
Patient is compliant with the medication and O Patient has experienced improved COPD symptom control (prescriber determined)	

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:

Fluticasone furoate with umeclidinium and vilanterol

and	possib	
		O 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)
	and	Clinical criteria:
		O Patient has a COPD Assessment Test (CAT) score greater than 10
		or O Patient has had 2 or more exacerbations in the previous 12 months
		O Patient has had one exacerbation requiring hospitalisation in the previous 12 months
		$^{\text{or}}$ O Patient has had an eosinophil count greater than or equal to 0.3 × 10 ⁹ cells/L in the previous 12 months
	or	

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:		

Budesonide with glycopyrronium and eformoterol

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)
		and	Clinical criteria:
			O Patient has a COPD Assessment Test (CAT) score greater than 10
			or O Patient has had 2 or more exacerbations in the previous 12 months
			O Patient has had one exacerbation requiring hospitalisation in the previous 12 months or
			O Patient has had an eosinophil count greater than or equal to 0.3 × 10 [^] 9 cells/L in the previous 12 months
	or		

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

Re-a	ssess	men	diopathic pulmonary fibrosis t required after 12 months			
Prere	Prerequisites (tick boxes where appropriate)					
(and			cribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.			
	(and	С	Patient has been diagnosed with idiopathic pulmonary fibrosis by a multidisciplinary team including a radiologist			
	and	С	Forced vital capacity is between 50% and 90% predicted			
	(and	С	Pirfenidone is to be discontinued at disease progression (See Notes)			
	(and		Pirfenidone is not to be used in combination with subsidised nintedanib			
		or	O The patient has not previously received treatment with nintedanib			
		or	O Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance			
			O Patient has previously received nintedanib, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with nintedanib)			
Re-a	ssess	men	PN – idiopathic pulmonary fibrosis t required after 12 months			
Prere	equisi	ites	(tick boxes where appropriate)			
(and			bribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.			
	(and	С	Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment			
	and (С	Pirfenidone is not to be used in combination with subsidised nintedanib			
	(С	Pirfenidone is to be discontinued at disease progression (See Note)			

Note: disease progression is defined as a decline in percent predicted FVC of 10% or more within any 12 month period.

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:

Nintedanib

			diopathic pulmonary fibrosis t required after 12 months	
Prere	Prerequisites (tick boxes where appropriate)			
(and			bribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.	
	(and	С	Patient has been diagnosed with idiopathic pulmonary fibrosis by a multidisciplinary team including a radiologist	
	(and	С	Forced vital capacity is between 50% and 90% predicted	
	(and	С	Nintedanib is to be discontinued at disease progression (See Note)	
	(and	С С	Nintedanib is not to be used in combination with subsidised pirfenidone	
		or	O The patient has not previously received treatment with pirfenidone	
		or	O Patient has previously received pirfenidone, but discontinued pirfenidone within 12 weeks due to intolerance	
			O Patient has previously received pirfenidone, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with pirfenidone)	
Re-a	ssess	men	N – idiopathic pulmonary fibrosis t required after 12 months (tick boxes where appropriate)	
(and	D F	Preso NZ H	bribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.	
	(and	С	Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment	
	(and	С	Nintedanib is not to be used in combination with subsidised pirfenidone	
	(C	Nintedanib is to be discontinued at disease progression (See Note)	

Note: disease progression is defined as a decline in percent predicted FVC of 10% or more within any 12 month period.

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:
lvaca	ftor				
INITIA Prere	equisi	i tes (ribed	boxes where appropriate) 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 O Patient has been diagnosed with cystic fibrosis		ent has been diagnosed with cystic fibrosis			
		or	0	Patient must have G551D mutation in the cystic fibrosis t 1 allele	transmembrane conductance regulator (CFTR) gene on at least
			Ο	Patient must have other gating (class III) mutation (G124 in the CFTR gene on at least 1 allele	4E, G1349D, G178R, G551S, S1251N, S1255P, S549N and S549R)
	and (С		ents must have a sweat chloride value of at least 60 mmol ction system	/L by quantitative pilocarpine iontophoresis or by Macroduct sweat
	and (and	С	Treat	tment with ivacaftor must be given concomitantly with star	dard therapy for this condition
	(С		ent must not have an acute upper or lower respiratory infec- iotics) for pulmonary disease in the last 4 weeks prior to c	ction, pulmonary exacerbation, or changes in therapy (including ommencing treatment with ivacaftor
	and	С	The o	dose of ivacaftor will not exceed one tablet or one sachet	twice daily
	and (С	Appli	icant has experience and expertise in the management of	cystic fibrosis

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:

Elexacaftor with tezacaftor, ivacaftor and ivacaftor

INITIATION

quis	ites	tick boxes where appropriate)	
(and	Ο	Patient has been diagnosed with cystic fibrosis	
and	0	Patient is 6 years of age or older	
		O Patient has two cystic fibrosis-causing mutations in the cystic fibrosis transmembrane regulator (CFTR) g parental allele)	gene (one from each
	or	O Patient has a sweat chloride value of at least 60 mmol/L by quantitative pilocarpine iontophoresis or by N collection system	Macroduct sweat
and O Patient has a heterozygous or homozygous F508del mutation			
		O Patient has a heterozygous or homozygous F508del mutation	
	or	O Patient has a G551D mutation or other mutation responsive in vitro to elexacaftor/tezacaftor/ivacaftor (se	ee note a)
O The treatment must be the sole funded CFTR modulator therapy for this condition			
and	Ο	Treatment with elexacaftor/tezacaftor/ivacaftor must be given concomitantly with standard therapy for this cond	lition
		ations are listed in the Food and Drug Administration (FDA) Trikafta prescribing information	

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:	

Dornase alfa

INITIATION – cystic fibrosis Re-assessment required after 12 months				
Prerequisites (tick boxes where appropriate)				
O Prescribed by, or recommended by a respiratory physician or paediatrician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
O Patient has a confirmed diagnosis of cystic fibrosis and				
O Patient has previously undergone a trial with, or is currently being treated with, hypertonic saline				
O Patient has required one or more hospital inpatient respiratory admissions in the previous 12 month period or				
O Patient has had 3 exacerbations due to CF, requiring oral or intravenous (IV) antibiotics in in the previous 12 month period or				
 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 				
O Patient has a diagnosis of allergic bronchopulmonary aspergillosis (ABPA)				
CONTINUATION - cystic fibrosis Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a respiratory physician or paediatrician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O The treatment remains appropriate and the patient continues to benefit from treatment				
INITIATION – significant mucus production Re-assessment required after 4 weeks Prerequisites (tick boxes where appropriate)				
Patient is an in-patient and O The mucus production cannot be cleared by first line chest techniques				
INITIATION – pleural emphyema Re-assessment required after 3 days Prerequisites (tick boxes where appropriate)				
O Patient is an in-patient				
O 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.

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	

Dexamethasone

INITIATION – Diabetic macular oedema
Re-assessment required after 12 months
Prerequisites (tick boxes 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.
O Patients have diabetic macular oedema with pseudophakic lens
O Patient has reduced visual acuity of between 6/9 – 6/48 with functional awareness of reduction in vision and
O Patient's disease has progressed despite 3 injections with bevacizumab or
O Patient is unsuitable or contraindicated to treatment with anti-VEGF agents
Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year
CONTINUATION – Diabetic macular oedema Re-assessment required after 12 months Prerequisites (tick boxes 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.
O Patient's vision is stable or has improved (prescriber determined)
O Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year
INITIATION – Women of child bearing age with diabetic macular oedema Re-assessment required after 12 months
Prerequisites (tick boxes 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.
Patients have diabetic macular oedema
Patient has reduced visual acuity of between 6/9 – 6/48 with functional awareness of reduction in vision and
O Patient is of child bearing potential and has not yet completed a family and
O Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year

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	ER		PATIENT:
Name	ə:			Name:
Ward	:			NHI:
Dexa	amet	has	one - continued	
Re-a	assess requisi	men ites		lema ance with a protocol or guideline that has been endorsed by the Health NZ
	 Patient's vision is stable or has improved (prescriber determined) and Patient is of child bearing potential and has not yet completed a family and Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year 			
\subseteq				

Various

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:

Deferasirox

Re-a		N ment required after 2 years ites (tick boxes where appropriate)	
and	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 The patient has been diagnosed with chronic iron overload due to congenital inherited anaemia and O Deferasirox is to be given at a daily dose not exceeding 40 mg/kg/day		
	and	 O Treatment with maximum tolerated doses of deferiprone monotherapy or deferiprone and desferrioxamine combination therapy have proven ineffective as measured by serum ferritin levels, liver or cardiac MRI T2* O Treatment with deferiprone has resulted in severe persistent vomiting or diarrhoea O Treatment with deferiprone has resulted in arthritis O Treatment with deferiprone is contraindicated due to a history of agranulocytosis (defined as an absolute neutrophil count (ANC) of < 0.5 cells per μL) or recurrent episodes (greater than 2 episodes) of moderate neutropenia (ANC 0.5 - 1.0 cells per μL) 	
Re-a	isses equi:	ATION ment required after 2 years ites (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.	
	or	 For the first renewal following 2 years of therapy, the treatment has been tolerated and has resulted in clinical improvement in all three parameters namely serum ferritin, cardiac MRI T2* and liver MRI T2* levels For subsequent renewals, the treatment has been tolerated and has resulted in clinical stability or continued improvement in all three parameters namely serum ferritin, cardiac MRI T2* and liver MRI T2* levels 	

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

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

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:	
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)

 $m O\,$ The treatment remains appropriate for the patient and the patient is benefiting from the treatment

Special Foods

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:

Carbohydrate

INITIATION – Use as an additive Prerequisites (tick boxes where appropriate)				
	0	Cystic fibrosis		
or	Ο	Chronic kidney disease		
or	Ο	Cancer in children		
or	Ο	Cancers affecting alimentary tract where there are malabsorption problems in patients over the age of 20 years		
or	Ο	Faltering growth in an infant/child		
or	Ο	Bronchopulmonary dysplasia		
or	Ο	Premature and post premature infant		
or	0	Inborn errors of metabolism		
INITIATI	ON - 1	Use as a module		

Prerequisites (tick box where appropriate)

O For use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

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:
Fat				
			Use as an additive (tick boxes where appropriate)	
		0	Patient has inborn errors of metabolism	
	or	0	Faltering growth in an infant/child	
	or	Ο	Bronchopulmonary dysplasia	
	or	Ο	Fat malabsorption	
	or or	Ο	Lymphangiectasia	
	or	Ο	Short bowel syndrome	
	or	Ο	Infants with necrotising enterocolitis	
	or	Ο	Biliary atresia	
		Ο	For use in a ketogenic diet	
	or	Ο	Chyle leak	
	or	Ο	Ascites	
	or	Ο	Patient has increased energy requirements, and for whom	dietary measures have not been successful

INITIATION – Use as a module

Prerequisites (tick box where appropriate)

O For use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk. Note: Patients are required to meet any Special Authority criteria associated with all 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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Protein	
INITIATION – Use as an additive Prerequisites (tick boxes where appropriate)	
or O High protein needs	
INITIATION – Use as a module	

Prerequisites (tick box where appropriate)

O For use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk. Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

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:
Carbohydrate and fat cumplement	

Carbohydrate and fat supplement

(and	С	Infar	nt or child aged four years or under	
unu		0	Cystic fibrosis	
	or	Ο	Cancer in children	
	or	Ο	Faltering growth	
	or	Ο	Bronchopulmonary dysplasia	
	or	Ο	Premature and post premature infants	

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:
Metabolic Products	
INITIATION Prerequisites (tick boxes where appropriate)	
O For the dietary management of inherited metabolic disease	
O Patient has adrenoleukodystrophy	

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:

Diabetic Products

INITI Prere			(tick boxes where appropriate)
		Ο	For patients with type I or type II diabetes suffering weight loss and malnutrition that requires nutritional support
	or	Ο	For patients with pancreatic insufficiency
	or	Ο	For patients who have, or are expected to, eat little or nothing for 5 days
	or	Ο	For patients who have a poor absorptive capacity and/or high nutrient losses and/or increased nutritional needs from causes such as catabolism
	or	0	For use pre- and post-surgery
	or	0	For patients being tube-fed
	or	0	For tube-feeding as a transition from intravenous nutrition

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:
Elemental and Semi-Elemental Products	

INITI. Prere			(tick boxes where appropriate)	
		0	Malabsorption	
	or	Ο	Short bowel syndrome	
	or	Ο	Enterocutaneous fistulas	
	or	Ο	Eosinophilic enteritis (including oesophagitis)	
	or	Ο	Inflammatory bowel disease	
	or or	Ο	Acute pancreatitis where standard feeds are not tolerated	
	U	Ο	Patients with multiple food allergies requiring enteral feeding	

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:
Fat-modified feed	
INITIATION Prerequisites (tick boxes where appropriate) O Patient has metabolic disorders of fat metabolism or O or O Modified as a modular feed, made from at least one nutrient m Pharmaceutical Schedule, for adults	nodule 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.

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

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:
Uinh Calavia Draduata	

High Calorie Products

NITIATION Prerequisites (†	(tick boxes where appropriate)
	Patient is fluid volume or rate restricted
or or	Patient requires low electrolyte
and	O Cystic fibrosis or O Any condition causing malabsorption or O Faltering growth in an infant/child or O Increased nutritional requirements O Patient has substantially increased metabolic requirements

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:
High protein enteral feed	
INITIATION Prerequisites (tick boxes where appropriate) O The patient has a high protein requirement and	
And O Patient has liver disease or O Patient is obese (BMI > 30) and is undergoing surgery or O Patient is fluid restricted or	

O Patient's needs cannot be more appropriately met using high calorie product

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:

Extensively hydrolysed formula

INITIATION Prerequisites (tick boxes where appropriate) Cows' milk formula is inappropriate due to severe intolerance or allergy to its protein content and Soy milk formula has been reasonably trialled without resolution of symptoms or Soy milk formula is considered clinically inappropriate or contraindicated or () Severe malabsorption or Short bowel syndrome or Intractable diarrhoea or Biliary atresia or Cholestatic liver diseases causing malsorption or Cystic fibrosis or () Proven fat malabsorption or Severe intestinal motility disorders causing significant malabsorption or ()Intestinal failure or For step down from Amino Acid Formula Note: A reasonable trial is defined as a 2-4 week trial, or signs of an immediate IgE mediated allergic reaction.

CONTINUATION

and

 \bigcirc

Prerequisites (tick boxes where appropriate)

An assessment as to whether the infant can be transitioned to a cows' milk protein or soy infant formula has been undertaken

The outcome of the assessment is that the infant continues to require an extensively hydrolysed infant 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

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

and

The patient is fluid restricted or volume intolerant

The patient has increased nutritional requirements due to faltering growth ()

) Patient is under 18 months old and weighs less than 8kg

Note: 'Volume intolerant' patients are those who are unable to tolerate an adequate volume of infant formula to achieve expected growth rate. These patients should have first trialled appropriate clinical alternative treatments, such as concentrating, fortifying and adjusting the frequency of feeding.

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:

Enteral liquid peptide formula

INITIATION Prerequisites (tick boxes where appropriate) () Patient has impaired gastrointestinal function and either cannot tolerate polymeric feeds, or polymeric feeds are unsuitable and () Severe malabsorption or Short bowel syndrome or Intractable diarrhoea or Biliary atresia or Cholestatic liver diseases causing malabsorption or Cystic fibrosis or Proven fat malabsorption or Severe intestinal motility disorders causing significant malabsorption or Intestinal failure or 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 () A semi-elemental or partially hydrolysed powdered feed has been reasonably trialled and considered unsuitable or For step down from intravenous nutrition Note: A reasonable trial is defined as a 2-4 week trial. CONTINUATION Prerequisites (tick boxes where appropriate) An assessment as to whether the patient can be transitioned to a cows milk protein or soy infant formula or extensively hydrolysed formula has been undertaken and

The outcome of the assessment is that the patient continues to require an enteral liquid peptide formula

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:

Amino acid formula

INITIATION Prerequisites (tick boxes where appropriate) or O or Severe Immune deficiency

CONTINUATION

and

and

and

and

Prerequisites	(tick boxes	where	appropriate)	ĺ
---------------	-------------	-------	--------------	---

An assessment as to whether the infant can be transitioned to a cows' milk protein, soy, or extensively hydrolysed infant formula has been undertaken
 The outcome of the assessment is that the infant continues to require an amino acid infant formula

 ${\sf O}$ Amino acid formula is required for a nutritional deficit

INITIATION – patients who are currently funded under RS1502 or SA1557

Re-assessment required after 3 months **Prerequisites** (tick boxes where appropriate)

Patient has a valid initiation or renewal approval for extensively hydrolysed formula (RS1502)

Patient is unable to source funded Aptamil powder at this time

The approval only applies to funded dispensings of Neocate Gold and Neocate Syneo

Note: This criteria is short term funding to cover an out-of-stock situation on some extensively hydrolysed formula powder funded under Hospital Restriction RS1502. There is no continuation criteria under this criterion.

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:	
High fat formula		

INITIATION

Prerequisites (tick box where appropriate)

()For patients with intractable epilepsy, pyruvate dehydrogenase deficiency or glucose transported type-1 deficiency and other conditions requiring a ketogenic diet

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 Products

IITIATI rerequ		s (tick b	poxes where appropriate)
an	O d	Child	d is aged one to ten years
	ο	0	The child is being fed via a tube or a tube is to be inserted for the purposes of feeding
		Ο	Any condition causing malabsorption
	0	Ο	Faltering growth in an infant/child
	0	\bigcirc	Increased nutritional requirements
	0	\bigcirc	The child is being transitioned from TPN or tube feeding to oral feeding
	0	Ó	The child has eaten, or is expected to eat, little or nothing for 3 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.

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	

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	

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:		
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

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:
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, head or neck surgery

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:	
Standard Feeds		

INITIATION

Fo	tients with malnutrition, defined as any of the following:	
	O BMI < 18.5	
ľ	O Greater than 10% weight loss in the last 3-6 months	
ſ	O BMI < 20 with greater than 5% weight loss in the last 3-6 months	
or		
C	or patients who have, or are expected to, eat little or nothing for 5 days	
or C	or patients who have a poor absorptive capacity and/or high nutrient losses and/or increased nutritional needs from c atabolism	auses such as
C	or use pre- and post-surgery	
or C	or patients being tube-fed	
or C	or tube-feeding as a transition from intravenous nutrition	
or	or any other condition that meets the community Special Authority criteria	

Vaccines

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:	

Diphtheria, tetanus, pertussis and polio vaccine

	Ο	A single dose for children up to the age of 7 who have completed primary immunisation
or or	0	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
U	Ο	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
or	Ο	Five doses will be funded for children requiring solid organ transplantation

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:	

Diphtheria, tetanus, pertussis, polio, hepatitis B and haemophilus influenzae type B vaccine

INIT Prer			(tick boxes where appropriate)
		0	Up to four doses for children under the age of 10 years for primary immunisation
	or	0	An additional four doses (as appropriate) for (re-)immunisation of children under the age of 18 years post haematopoietic stem cell transplantation
	or	Ο	An additional four doses (as appropriate) for (re-)immunisation of children under the age of 10 years who are post chemotherapy; pre or post splenectomy; undergoing renal dialysis and other severely immunosuppressive regimens
	or	0	Up to five doses for children under the age of 10 years receiving solid organ transplantation

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.

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:
Bacillus calmette-guerin vaccine			
INITIATION Prerequisites (tick boxes where appropriate)			
	For i	nfants at increased risk of tuberculosis defined as:	
	\bigcirc	Living in a house or family with a person with current or past h	istory of TB
	and	Having one or more household members or carers who within 100,000 for 6 months or longer	the last 5 years lived in a country with a rate of TB > or equal to 40 per
	and	During their first 5 years will be living 3 months or longer in a d	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

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:	

Diphtheria, tetanus and pertussis vaccine

INITIATION Prerequisites (tick boxes where appropriate) () A single dose for pregnant women in the second or third trimester of each pregnancy; or or 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 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 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 A single dose for vaccination of patients aged from 65 years old or A single dose for vaccination of patients aged from 45 years old who have not had 4 previous tetanus doses or For vaccination of previously unimmunised or partially immunised patients or For revaccination following immunosuppression or For boosting of patients with tetanus-prone wounds

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

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

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 vaccine

INITIATION Prerequisites (tick boxes where appropriate) () 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 One dose for close contacts of meningococcal cases of any group or One dose for person who has previously had meningococcal disease of any group or A maximum of two doses for bone marrow transplant patients or A maximum of two doses for person pre and post-immunosuppression* or () Person is aged between 13 and 25 years, inclusive and \bigcirc 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 or ()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 28 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.

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	

Meningococcal (A, C, Y and W-135) conjugate vaccine

		Children under 12 months of age (tick boxes where appropriate)
	0	A maximum of three doses (dependant on age at first dose) 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 or	Ο	A maximum of three doses (dependant on age at first dose) for close contacts of meningococcal cases of any group
or	Ο	A maximum of three doses (dependant on age at first dose) for child who has previously had meningococcal disease of any group
or	0	A maximum of three doses (dependant on age at first dose) for bone marrow transplant patients
	0	A maximum of three doses (dependant on age at first dose) for child pre- and post-immunosuppression*

Note: infants from 6 weeks to less than 6 months of age require a 2+1 schedule, infants from 6 months to less than 12 months of age require a 1+1 schedule. Refer to the Immunisation Handbook for recommended booster schedules with meningococcal ACWY vaccine. *Immunosuppression due to steroid or other immunosuppressive therapy must be for a period of greater than 28 days.

	klist to determine if a patient meets the restrictions for funding in the hospital setting . For more details, refer to Section H of the Pharmace r community funding, see the Special Authority Criteria.	utical
PRESCRIBEI	R PATIENT:	
Name:	Name:	
Ward:	NHI:	
Pneumoco	occal (PCV13) conjugate vaccine	
Re-assessme Prerequisite	 – Primary course for previously unvaccinated children aged under 5 years nent required after 3 doses es (tick box where appropriate) 	
	primary course of three doses for previously unvaccinated children up to the age of 59 months inclusive	
Re-assessme Prerequisite	 High risk individuals who have received PCV10 nent required after 2 doses es (tick box where appropriate) 	
	to doses are funded for high risk individuals (over the age of 12 months and under 18 years) who have previously received two doses of the mary course of PCV10	۱e
Re-assessme Prerequisite	 High risk children aged under 5 years hent required after 4 doses es (tick boxes where appropriate) Up to an additional four doses (as appropriate) are funded for the (re)immunisation of high-risk children aged under 5 years 	
and	O On immunosuppressive therapy or radiation therapy, vaccinate when there is expected to be a sufficient immune response	
c	or O Primary immune deficiencies	
C	or HIV infection	
C	or O Renal failure, or nephrotic syndrome	
C	or O Are immune-suppressed following organ transplantation (including haematopoietic stem cell transplant)	
c	or O Cochlear implants or intracranial shunts	
c	or O Cerebrospinal fluid leaks	
c	or O Receiving corticosteroid therapy for more than two weeks, and who are on an equivalent daily dosage of prednisone of 2 mg/kg	
c	per day or greater, or children who weigh more than 10 kg on a total daily dosage of 20 mg or greater	
c	O Chronic pulmonary disease (including asthma treated with high-dose corticosteroid therapy) or	
c	O Pre term infants, born before 28 weeks gestation or	
	O Cardiac disease, with cyanosis or failure or	
	O Diabetes	
	or O Down syndrome	
C	or O Who are pre-or post-splenectomy, or with functional asplenia	

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:				
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 (reference)	e-)immunisation of individuals 5 years and over with HIV, pre or post bost splenectomy; functional asplenia, pre- or post- solid organ transplant, ear implants, intracranial shunts, cerebrospinal fluid leaks or primary				
INITIATION – Testing for primary immunodeficiency diseases Prerequisites (tick box where appropriate) O For use in testing for primary immunodeficiency diseases, on the red	INITIATION – Testing for primary immunodeficiency diseases				
Note: Please refer to the Immunisation Handbook for the appropriate schedu	ule for catch up programmes				

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:	
Pneumococcal (PPV23) polysaccharide vaccine		
INITIATION – High risk patients Re-assessment required after 3 doses Prerequisites (tick box where appropriate) O For patients with HIV, for patients post haematopoietic stem cell transplant, or chemotherapy; pre- or post-splenectomy; or with functional asplenia, pre- or post-solid organ transplant, renal dialysis, complement deficiency (acquired or inherited), cochlear implants, or primary immunodeficiency		
INITIATION – High risk children Re-assessment required after 2 doses Prerequisites (tick boxes where appropriate)		
O Patient is a child under 18 years for (re-)immunisation and		
On immunosuppressive therapy or radiation therapy, vac or O With primary immune deficiencies or With HIV infection or With renal failure, or nephrotic syndrome or Who are immune-suppressed following organ transplant or With cochlear implants or intracranial shunts or With cerebrospinal fluid leaks or	ks, and who are on an equivalent daily dosage of prednisone of 2 mg/kg kg on a total daily dosage of 20 mg or greater ed with high-dose corticosteroid therapy)	

INITIATION – Testing for primary immunodeficiency diseases Prerequisites (tick box where appropriate)

O For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician

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:
Salmonella typhi vaccine	
INITIATION Prerequisites (tick box where appropriate)	
O For use during typhoid fever outbreaks	

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	CRI	RFR		PATIENT:
Name	9:			Name:
Ward:				NHI:
Meni	ingo	ocod	cal B multicomponent vaccine	
INITIATION – Primary immunisation for children up to 12 months of age Re-assessment required after 3 doses				
Prere	equi	sites	(tick boxes where appropriate)	
	or	O Three doses for children up to 12 months of age (inclusive) for primary immunisation		
	O 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			
INITIATION – Person is one year of age or over Prerequisites (tick boxes where appropriate)				
	or	0	Up to two doses and a booster every five years for patients prasplenia, HIV, complement deficiency (acquired or inherited),	e- and post-splenectomy and for patients with functional or anatomic or pre- or post-solid organ transplant
		Ο	Up to two doses for close contacts of meningococcal cases of	any group
	or or	Ο	Up to two doses for person who has previously had meningoc	occal disease of any group
	or	Ο	Up to two doses for bone marrow transplant patients	
		Ο	Up to two doses for person pre- and post-immunosuppression	•

INITIATION - Person is aged between 13 and 25 years (inclusive)

Re-assessment required after 2 doses **Prerequisites** (tick boxes where appropriate)

and		
tertiary education hall		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
	or	m O Two doses for individuals who turn 13 years 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.

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	CRI	BER		PATIENT:
Name	:			Name:
Ward:				NHI:
Нера	Hepatitis A vaccine			
INITI Prere			(tick boxes where appropriate)	
		Ο	Two vaccinations for use in transplant patients	
	or	Ο	Two vaccinations for use in children with chronic liver disease	
	or	0	One dose of vaccine for close contacts of known hepatitis A ca	ases

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:

Hepatitis B recombinant vaccine

INITIATION Prerequisites (tick boxes where appropriate) () For household or sexual contacts of known acute hepatitis B patients or hepatitis B carriers or For children born to mothers who are hepatitis B surface antigen (HBsAg) positive or 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 ()For HIV positive patients or For hepatitis C positive patients or For patients following non-consensual sexual intercourse or For patients prior to planned immunosuppression for greater than 28 days or () For patients following immunosuppression or For solid organ transplant patients or For post-haematopoietic stem cell transplant (HSCT) patients or Following needle stick injury or For dialysis patients or For liver or kidney transplant patients

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:	

Hepatitis B recombinant vaccine

INITIATION Prerequisites (tick boxes where appropriate) () For household or sexual contacts of known acute hepatitis B patients or hepatitis B carriers or For children born to mothers who are hepatitis B surface antigen (HBsAg) positive or 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 ()For HIV positive patients or For hepatitis C positive patients or For patients following non-consensual sexual intercourse or For patients prior to planned immunosuppression for greater than 28 days or () For patients following immunosuppression or For solid organ transplant patients or For post-haematopoietic stem cell transplant (HSCT) patients or Following needle stick injury

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:
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 or O or O Rheumatic heart disease or O or O or O or O or O or O or O	
O Cerebro-vascular disease	

INITIATION – chronic respiratory disease

or

Prerequisites (tick boxes where appropriate)

O Asthma, if on a regular preventative therapy

O Other chronic respiratory disease with impaired lung function

Note: hypertension and/or dyslipidaemia without evidence of end-organ disease is excluded from funding.

Note: asthma not requiring regular preventative therapy is excluded from funding.

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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:

Influenza vaccine Inj 60 mcg in 0.5 ml syringe (quadrivalent vaccine) - continued

	, 	Ο	Diabetes
	or	0	Chronic renal disease
	or	Ο	Any cancer, excluding basal and squamous skin cancers if not invasive
	or	0	Autoimmune disease
	or	Ο	Immune suppression or immune deficiency
	or	Ο	HIV
	or	0	Transplant recipient
	or	Ο	Neuromuscular and CNS diseases/ disorders
	or	Ο	Haemoglobinopathies
	or	0	Is a child on long term aspirin
	or	Ο	Has a cochlear implant
	or	Ο	Errors of metabolism at risk of major metabolic decompensation
	or	Ο	Pre and post splenectomy
	or	Ο	Down syndrome
	or	Ο	Is pregnant
	or	0	Is a child 4 years of age or under (inclusive) who has been hospitalised for respiratory illness or has a history of significant respiratory illness
or (Patie Hosp	nts in a long-stay inpatient mental health care unit or who are compulsorily detained long-term in a forensic unit within a Public ital
ΓΙΟΝ	1 – S	eriou	us mental health conditions or addiction

 or
 O
 Schizophrenia

 or
 Major depressive disorder

 or
 O
 Bipolar disorder

 or
 O
 Schizoaffective disorder

 or
 O
 Schizoaffective disorder

 or
 O
 Person is currently accessing secondary or tertiary mental health and addiction services

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:
Measle	s, mumps and rubella vaccine	
Re-asse	${ m O}~$ For revaccination following immunosuppression	
Re-asse	${igodoldoldoldoldoldoldoldoldoldoldoldoldol$	

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

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) O For partially vaccinated or previously unvaccinated individual or O For revaccination following immunosuppression	s

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

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:
ame: Name:	
Ward: NHI:	
ccine [Chickenpox vaccine]	
primary vaccinations nt required after 1 dose (tick boxes where appropriate)	
Any infant born on or after 1 April 2016 For previously unvaccinated children turning 11 years old on o (chickenpox)	or after 1 July 2017, who have not previously had a varicella infection
other conditions nt required after 2 doses (tick boxes where appropriate)	
for non-immune patients: O With chronic liver disease who may in future be candidated O With deteriorating renal function before transplantation O Prior to solid organ transplant O Prior to any elective immunosuppression* O For post exposure prophylaxis who are immune competent For patients at least 2 years after bone marrow transplantation For patients at least 6 months after completion of chemotherate For HIV positive patients non immune to varicella with mild or For patients with inborn errors of metabolism at risk of major response For household contacts of paediatric patients who are immune	ent inpatients n, on advice of their specialist py, on advice of their specialist moderate immunosuppression on advice of HIV specialist netabolic decompensation, with no clinical history of varicella becompromised, or undergoing a procedure leading to immune compromise
	ccine [Chickenpox vaccine] mimary vaccinations trequired after 1 dose (tick boxes where appropriate) Any infant born on or after 1 April 2016 For previously unvaccinated children turning 11 years old on or (chickenpox) where conditions trequired after 2 doses (tick boxes where appropriate) for non-immune patients: O With chronic liver disease who may in future be candida O With deteriorating renal function before transplantation O Prior to solid organ transplant O Prior to any elective immunosuppression* For patients at least 2 years after bone marrow transplantation For patients at least 6 months after completion of chemothera For HIV positive patients non immune to varicella with mild or For patients with inborn errors of metabolism at risk of major r For household contacts of paediatric patients who are immune

greater than 28 days

I confirm that the above details are correct:

Signed: Date:

and

and

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:		

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)	
O Children aged 14 years and under	

(or	O Up to 3 doses for people aged 15 to 26 years inclusive O People aged 9 to 26 years inclusive and O Up to 3 doses for confirmed HIV infection or O Up to 3 doses people with a transplant (including stem cell) or O Up to 4 doses for Post chemotherapy
	N – Recurrent Respiratory Papillomatosis sites (tick boxes where appropriate) O Maximum of two doses for children aged 14 years and under

	\sim			
1	\cup	Maximum of three doses for pe	ople aged 15 years and ove	r

 $m O\,$ The person has recurrent respiratory papillomatosis

The person has not previously had an HPV vaccine

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

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	CRI	BER		PATIENT:
Name	:			Name:
Ward:				NHI:
Varic	ella	a zos	ster vaccine [shingles vaccine]	
			people aged 18 years and over (Shingrix) t required after 2 doses	
Prere	qui	sites	(tick boxes where appropriate)	
		0	Pre- and post-haematopoietic stem cell transplant or cellular th	nerapy
	or	Ο	Pre- or post-solid organ transplant	
	or	Ο	Haematological malignancies	
	or or	Ο	People living with poorly controlled HIV infection	
	01	Ο	Planned or receiving disease modifying anti-rheumatic drugs (polymyalgia rheumatica, systemic lupus erythematosus or rhe	DMARDs – targeted synthetic, biologic, or conventional synthetic) for unatoid arthritis
	or	Ο	End stage kidney disease (CKD 4 or 5);	
	or	0	Primary immunodeficiency	

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)

m O Up to three doses for previously unvaccinated children aged 6 months – 4 years at high risk of severe illness

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	e:			Name:
Ward	l:			NHI:
cov	'ID-	19 va	accine	
			initial dose (tick boxes where appropriate)	
		0	One dose for previously unvaccinated children aged 5-11 year	s old
	or	0	Up to three doses for immunocompromised children aged 5-11	l years old

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

	nitial dose (tick boxes where appropriate)
O	One dose for previously unvaccinated people aged 12-15 years old
	Up to three doses for immunocompromised people aged 12-15 years old
or O	Up to two doses for previously unvaccinated people 16-29 years old
or O	Up to four doses for people aged 16-29 at high risk of severe illness
0	One dose for previously unvaccinated people aged 30 and older

INITIATION – additional dose

Prerequisites (tick box where appropriate)

O One additional dose every 6 months for people aged 30 years and over, additional dose is given at least 6 months after last dose

CONTINUATION – additional dose

Prerequisites (tick box where appropriate)

O One additional dose every 6 months for people aged 30 years and over, additional dose is given at least 6 months after last dose

I confirm that the above details are correct:

Signed: Date:

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Ceftazadime (RS1048)	142	Gefitinib (RS2079)	296
Cetuximab (RS2064)		Gemtuzumab ozogamicin (RS1923)	
Chlorhexidine with cetrimide (RS1683)		Haemophilus influenzae type B vaccine (RS1520)	
Chloroquine phosphate (RS1093)		Hepatic Products (RS1217)	
Cidofovir (RS1108)		Hepatitis A vaccine (RS1638)	
Cinacalcet (RS1931)		Hepatitis B recombinant vaccine (RS2050)	
		Hepatitis B recombinant vaccine (RS2030)	
Ciprotioxacin (BS1055)			
Ciprofloxacin (RS1055) Clarithromycin (RS1709)		High Calorie Products (RS1317)	

High fat formula (RS1225)	483 N
High protein enteral feed (RS1327)	477 N
Human papillomavirus (6, 11, 16, 18, 31, 33, 45, 52 and 58) vaccin	ie [HPV] N
(RS2038)	
Hydralazine hydrochloride - Tab 25 mg (RS1008)	
Hyoscine hydrobromide - Patch 1.5 mg (RS1155)	241 O
Ibrutinib (RS1933)	273 0
Icatibant (RS1501)	445 O
Idarucizumab (RS1535)	
Idursulfase (RS1546)	
lloprost (RS1985)	
Imipenem with cilastatin (RS1046)	
Infliximab (RS2065)	
Influenza vaccine Inj 60 mcg in 0.5 ml syringe (quadrivalent vaccine) (F	
506 Interferon gamma (RS1113)	
Isoniazid (RS1281) Isoniazid with rifampicin (RS1282)	
Itraconazole (RS1073)	
Ivabradine (RS1566) Ivacaftor (RS1818)	
Ivermectin (RS1283)	
Ketoconazole - Tab 200 mg (RS1410)	
L-ornithine L-aspartate (RS1261)	
Lacosamide (RS1988)	
Lapatinib (RS1828)	
Laronidase (RS1607)	
Ledipasvir with sofosbuvir (RS1528)	
Lenalidomide (RS2044)	275 P
Lenvatinib (RS2098)	287 P
Levocarnitine (RS1035)	20 P
Levosimendan (RS1007)	
Lincomycin (RS1065)	
Linezolid (RS1066)	
Liothyronine sodium - Tab 20 mcg (RS1301)	130 Pi
Liraglutide (RS2096)	
Lisdexamfetamine dimesilate (RS2070)	
Long-acting Somatostatin Analogues (RS2100)	
Long-acting muscarinic antagonists with long-acting beta-adrenoceptor	or agonists P
(RS1518)	450 P
(RS1518) Low electrolyte oral feed (RS1227)	450 Po 485 Po
(RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228)	450 Po 485 Po 486 Po
(RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689)	450 Pr 485 Pr 486 Pr 68 Pr
(RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299)	450 Po 485 Po 486 Po 68 Po 108 P
(RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487)	450 Po 485 Po 68 Po 68 Po 108 Po 508 Po
(RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094)	450 Po 485 Po 68 Po 68 Po 108 Po 108 Po 108 Po 195 Po
(RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576)	450 P 485 P 486 P 68 P 68 P
(RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019)	450 P 485 P 486 P 68 P 508 P 508 P 195 P 253 P 496 P
(RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576)	450 P 485 P 486 P 68 P 508 P 508 P 195 P 253 P 496 P 497 P
(RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037)	450 P4 485 P4 486 P4 68 P4 508 P4 195 P 253 P 496 P 497 P 502 P
(RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635)	450 P4 485 P 486 P 68 P 508 P 508 P 253 P 496 P 496 P 502 P 369 P 269 P
(RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047)	450 P4 485 P 486 P 68 P 508 P 508 P 195 P 253 P 496 P 497 P 502 P 502 P 369 P 269 P 141 P
(RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal B multicomponent vaccine (RS2020) Meningococcal (RS2024) Meropenem (RS1047) Metabolic Products (RS2047)	450 P4 485 P4 486 P4 68 P4 508 P 108 P 508 P 195 P 253 P 496 P 502 P 502 P 369 P 269 P 269 P 141 P
(RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Metabolic Products (RS2047) Methoxyflurane (RS1292)	450 P4 485 P4 486 P4 68 P4 508 P 108 P 508 P 195 P 253 P 496 P 497 P 502 P 369 P 269 P 269 P 141 P 471 Q 235 R
(RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1047) Metabolic Products (RS2047) Methoxyflurane (RS1292) Methyl aminolevulinate hydrochloride (RS1127)	450 P4 485 P4 486 P4 68 P4 508 P 108 P 508 P 195 P 253 P 496 P 497 P 502 P 369 P 269 P 269 P 141 P 471 Q 235 R 112 R
 (RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Metabolic Products (RS2047) Methyl aminolevulinate hydrochloride (RS1127) Methylaltrexone bromide (RS2057) 	450 P4 485 P4 486 P4 68 P4 508 P 108 P 508 P 253 P 496 P 497 P 502 P 369 P 269 P 269 P 141 P 235 R 112 R 112 R
 (RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1047) Metabolic Products (RS2047) Methyl aminolevulinate hydrochloride (RS1127) Methylnaltrexone bromide (RS2057) Methylphenidate hydrochloride (RS2072) 	450 P4 485 P4 486 P4 68 P4 508 P 108 P 508 P 195 P 253 P 496 P 497 P 502 P 369 P 269 P 269 P 141 P 235 R 112 R 112 R 117 R
(RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Methoxyflurane (RS1292) Methyl aminolevulinate hydrochloride (RS1127) Methylnaltrexone bromide (RS2057) Methylphenidate hydrochloride (RS2072) Midodrine (RS1427)	450 P4 485 P 486 P 508 P 508 P 508 P 508 P 496 P 496 P 497 P 502 P 369 P 269 P 269 P 141 P 471 Q 235 R 112 R 17 R 17 R 258 R
(RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Metabolic Products (RS2047) Methoxyflurane (RS1292) Methyl aminolevulinate hydrochloride (RS1127) Methylphenidate hydrochloride (RS2072) Midodrine (RS1427) Midostaurin (RS2033)	450 P4 485 P 486 P 508 P 508 P 508 P 508 P 496 P 496 P 497 P 502 P 369 P 269 P 269 P 141 P 471 Q 235 R 112 R 17 R 258 R 285 R
(RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Methoxyflurane (RS1292) Methyl aminolevulinate hydrochloride (RS1127) Methylphenidate hydrochloride (RS2072) Midodrine (RS1427) Midostaurin (RS2033) Modafinil (RS2073)	450 P4 485 P 486 P 508 P 108 P 508 P 195 P 253 P 496 P 496 P 497 P 502 P 369 P 269 P 141 P 471 Q 235 R 112 R 112 R 112 R 258 R 82 R 285 R
 (RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Methoxyflurane (RS1292) Methyl aminolevulinate hydrochloride (RS1127) Methylphenidate hydrochloride (RS2072) Midodrine (RS1427) Midostaurin (RS2033) Modafinil (RS2073) 	450 P4 485 P 486 P 508 P 108 P 508 P 195 P 253 P 496 P 496 P 497 P 502 P 369 P 269 P 141 P 471 Q 235 R 112 R 112 R 258 R 258 R 2256 R 256 R
 (RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Methoxyflurane (RS1292) Methyl aminolevulinate hydrochloride (RS1127) Methylaltrexone bromide (RS2057) Methylnaltrexone bromide (RS2072) Midodrine (RS1427) Midostaurin (RS2033) Moroctocog alfa [Recombinant factor VIII] (RS1706) Moxifloxacin (RS1644) 	450 P4 485 P 486 P 508 P 508 P 508 P 508 P 253 P 496 P 496 P 502 P 369 P 269 P 269 P 141 P 471 Q 235 R 112 R 235 R 112 R 258 R 258 R 256 R 256 R 56 R 152 R
 (RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Methoxyflurane (RS1292) Methyl aminolevulinate hydrochloride (RS1127) Methylaltrexone bromide (RS2057) Methylnaltrexone bromide (RS2072) Midodrine (RS1427) Midostaurin (RS2033) Moroctocog alfa [Recombinant factor VIII] (RS1706) Moxifloxacin (RS1644) Multiple Sclerosis (RS1993) 	450 P4 485 P 486 P 508 P 508 P 508 P 508 P 253 P 496 P 496 P 502 P 369 P 269 P 269 P 141 P 471 Q 235 R 112 R 471 Q 235 R 258 R 256 R 256 R 56 R 152 R
 (RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Methoxyflurane (RS1292) Methyl aminolevulinate hydrochloride (RS1127) Methylnaltrexone bromide (RS2057) Methylnaltrexone bromide (RS2072) Midodrine (RS1427) Midostaurin (RS2033) Modafinil (RS2073) Moroctocog alfa [Recombinant factor VIII] (RS1706) Moxifloxacin (RS1644) Multiple Sclerosis (RS1993) Multiple Sclerosis (RS1997) 	450 P4 485 P 486 P 68 P 508 P 508 P 195 P 253 P 496 P 497 P 369 P 269 P 369 P 269 P 141 P 471 Q 235 R 112 R 471 Q 235 R 112 R 258 R 285 R 285 R 285 R 285 R 285 R 285 R
 (RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Methoxyflurane (RS1292) Methyl aminolevulinate hydrochloride (RS1127) Methylphenidate hydrochloride (RS2072) Midodrine (RS1427) Midostaurin (RS2033) Moodafinil (RS2073) Moroctocog alfa [Recombinant factor VIII] (RS1706) Moxifloxacin (RS1644) Multiple Sclerosis (RS1993) Multiple Sclerosis (RS1997) Multivitamin and mineral supplement (RS1498) Multivitamin renal (RS1499) 	450 P4 485 P 486 P 68 P 508 P 195 P 253 P 496 P 497 P 502 P 369 P 269 P 269 P 141 P 369 P 269 P 141 P 471 Q 235 R 112 R 17 R 258 R 256 R 256 R 256 R 152 R 249 R 251 R 249 R
 (RS1518) Low electrolyte oral feed (RS1227) Low electrolyte oral feed (RS1228) Lysine acetylsalicylate (RS1689) Mafenide acetate (RS1299) Measles, mumps and rubella vaccine (RS1487) Mefloquine hydrochloride (RS1094) Melatonin (RS1576) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019) Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037) Meningococcal B multicomponent vaccine (RS2020) Mepolizumab (RS2024) Mercaptopurine (RS1635) Meropenem (RS1047) Methoxyflurane (RS1292) Methyl aminolevulinate hydrochloride (RS1127) Methylphenidate hydrochloride (RS2072) Midodrine (RS1427) Midostaurin (RS2033) Moodafinil (RS2073) Moroctocog alfa [Recombinant factor VIII] (RS1706) Moxifloxacin (RS1644) Multiple Sclerosis (RS1993) Multiple Sclerosis (RS1997) Multivitamin and mineral supplement (RS1498) Multivitamin renal (RS1499) 	450 P4 485 P 486 P 68 P 508 P 195 P 253 P 496 P 497 P 502 P 369 P 269 P 269 P 141 P 369 P 269 P 141 P 471 Q 235 R 112 R 17 R 258 R 256 R 256 R 256 R 152 R 249 R 251 R 249 R
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