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

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Icatibant

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

- ○ Prescribed by, or recommended by a clinical immunologist or relevant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ○ 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

and

- ○ 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)

- ○ The treatment remains appropriate and the patient is benefiting from treatment

I confirm that the above details are correct:

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