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: ....

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)

- ◯ Ocular neovascularisation
- **or** ◯ Exudative ocular angiopathy

HOSPITAL

I confirm that the above details are correct:

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