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: .....

Dornase alfa

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

- ○ 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

- ○ Patient has a confirmed diagnosis of cystic fibrosis

and

- ○ Patient has previously undergone a trial with, or is currently being treated with, hypertonic saline

and

- ○ Patient has required one or more hospital inpatient respiratory admissions in the previous 12 month period

or

- ○ 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

or

- ○ Patient has a diagnosis of allergic bronchopulmonary aspergillosis (ABPA)

CONTINUATION – cystic fibrosis
Prerequisites (tick box where appropriate)

- ○ 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

- ○ 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

- ○ 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)

- ○ Patient is an in-patient

and

- ○ Patient diagnoses with pleural emphyema

HOSPITAL

I confirm that the above details are correct:

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