

Use this checklist to determine if a patient meets the restrictions for funding 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: .....

**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

- Wet age-related macular degeneration (wet AMD)  
or  
 Polypoidal choroidal vasculopathy  
or  
 Choroidal neovascular membrane from causes other than wet AMD

and

- The patient has developed severe endophthalmitis or severe posterior uveitis following treatment with bevacizumab  
or  
 There is worsening of vision or failure of retina to dry despite three intraocular injections of bevacizumab four weeks apart

and

- There is no structural damage to the central fovea of the treated eye  
and  
 Patient has not previously been treated with aflibercept for longer than 3 months

- or  
 Patient has current approval to use aflibercept for treatment of wAMD and was found to be intolerant to aflibercept within 3 months

**CONTINUATION – Wet Age Related Macular Degeneration**

Re-assessment required after 12 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

- Documented benefit must be demonstrated to continue  
and  
 Patient's vision is 6/36 or better on the Snellen visual acuity score  
and  
 There is no structural damage to the central fovea of the treated eye

I confirm that the above details are correct:

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