HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:	
Emicizumab				
INITIATION – Severe Haemophilia A with or without FVIII inhibitors 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 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 weekly	3 mg/kg weekly for 4 weeks followed by the equivalent of 1.5 mg/kg	

I confirm that the above details are correct:	
Signed:	Date: