I confirm that the above details are correct:

Signed: Date:

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.

PRESC	RIBER	PATIENT:
Name:		
Ward:		NHI:
Mepol	izuma	b
Re-ass	essmen juisites Preso	Severe eosinophilic asthma t required after 12 months (tick boxes where appropriate) cribed by, or recommended by a respiratory physician or clinical immunologist, or in accordance with a protocol or guideline that has been resed by the Health NZ Hospital.
		Patient must be aged 12 years or older Patient must have a diagnosis of severe eosinophilic asthma documented by a respiratory physician or clinical immunologist
а	and O	Conditions that mimic asthma eg. vocal cord dysfunction, central airway obstruction, bronchiolitis etc. have been excluded Patient has a blood eosinophil count of greater than 0.5 × 10^9 cells/L in the last 12 months
а	and or	Patient must be adherent to optimised asthma therapy including inhaled corticosteroids (equivalent to at least 1000 mcg per day of fluticasone propionate) plus long acting beta-2 agonist, or budesonide/formoterol as part of the single maintenance and reliever therapy regimen, unless contraindicated or not tolerated O Patient has had at least 4 exacerbations needing systemic corticosteroids in the previous 12 months, where an exacerbation is defined as either documented use of oral corticosteroids for at least 3 days or parenteral corticosteroids O Patient has received continuous oral corticosteroids of at least the equivalent of 10 mg per day over the previous 3 months
а	and O and O and	Treatment is not to be used in combination with subsidised benralizumab Patient has an Asthma Control Test (ACT) score of 10 or less. Baseline measurements of the patient's asthma control using the ACT and oral corticosteroid dose must be made at the time of application, and again at around 52 weeks after the first dose to assess response to treatment
	or	O Patient has not previously received an anti-IL5 biological therapy for their severe eosinophilic asthma O Patient was refractory or intolerant to previous anti-IL5 biological therapy and O Patient was not eligible to continue treatment with previous anti-IL5 biological therapy and discontinued within 12 months of commencing treatment
Re-ass	essmen uisites Preso	ON – Severe eosinophilic asthma t required after 2 years (tick boxes where appropriate) cribed by, or recommended by a respiratory physician or clinical immunologist, or in accordance with a protocol or guideline that has been
and	endo	An increase in the Asthma Control Test (ACT) score of at least 5 from baseline C Exacerbations have been reduced from baseline by 50% as a result of treatment with mepolizumab
	or	O Reduction in continuous oral corticosteroid use by 50% or by 10 mg/day while maintaining or improving asthma control

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PRESCRIBER		PATIENT:					
Name:		Name:					
Ward:		NHI:					
Mepolizumab	- continued						
	osinophilic granulomatosis with polyangiitis						
Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)							
	n at least one of the following for at least three months (unless						
and	contraindicated to all): azathioprine, cyclophosphamide, leflunomide, methotrexate, mycophenolate, or rituximab						
or	The patient has trialled prednisone for a minimum of thre 7.5 mg per day	ee months and is unable to maintain disease control at doses below					
	O Corticosteroids are contraindicated						
Re-assessment r	I – eosinophilic granulomatosis with polyangiitis required after 12 months ick box where appropriate)						
O Patient	has no evidence of clinical disease progression						

I confirm that the above details are correct:

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Signed.	Date:	
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