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Alimentary Tract and Metabolism

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:
Calcium carbonate	

Prerequisites (tick box where appropriate)

O Only when prescribed for patients unable to swallow calcium carbonate tablets or where calcium carbonate tablets are inappropriate.

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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:

Budesonide

INITIATION – Crohn's disease Prerequisites (tick boxes where appropriate)			
an	and O Mild to moderate ileal, ileocaecal or proximal Crohn's disease and O Diabetes or O Cushingoid habitus or O Osteoporosis where there is significant risk of fracture or		
	 Severe acne following treatment with conventional corticosteroid therapy History of severe psychiatric problems associated with corticosteroid treatment History of major mental illness (such as bipolar affective disorder) where the risk of conventional corticosteroid treatment causing relapse is considered to be high Relapse during pregnancy (where conventional corticosteroids are considered to be contraindicated) 		
INITIATION – Collagenous and lymphocytic colitis (microscopic colitis) Prerequisites (tick box where appropriate) O Patient has a diagnosis of microscopic colitis (collagenous or lymphocytic colitis) by colonoscopy with biopsies			
	isites	Gut Graft versus Host disease (tick box where appropriate) ent has gut Graft versus Host disease following allogenic bone marrow transplantation	

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.

PRES	CRIB	ER			PATIENT:
Name:					Name:
Ward:					NHI:
Bude	son	ide	- con	tinued	
Re-as	sess	men	it requi	rrhotic autoimmune hepatitis red after 6 months oxes where appropriate)	
	(С	Patier	nt has autoimmune hepatitis*	
	and (and	С	Patier	nt does not have cirrhosis	
			Ο	Diabetes	
		or or	0	Cushingoid habitus	
		or	Ο	Osteoporosis where there is significant risk of fracture	
			Ο	Severe acne following treatment with conventional cortic	osteroid therapy
	O History of severe psychiatric problems associated with corticosteroid treatment		orticosteroid treatment		
		or		History of major mental illness (such as bipolar affective causing relapse is considered to be high	disorder) where the risk of conventional corticosteroid treatment
		-	Ο	Relapse during pregnancy (where conventional corticost	eroids are considered to be contraindicated)
		or	Ο	Adolescents with poor linear growth (where conventional	corticosteroid use may limit further growth)
Note:	Indic	catio	ns ma	rked with * are unapproved indications.	
Re-as	sess	men	t requi	on-cirrhotic autoimmune hepatitis red after 6 months	
Prere				ox where appropriate)	
	ד ל	reatr	ment r	emains appropriate and the patient is benefitting from the	treatment

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.

PRES	CR	IBER	PATIENT:
Name	:		Name:
Ward:			NHI:
Rani	tid	ine	
INITI. Prere		ON isites (tick boxes where appropriate)	
	~	O For continuation use	
	or	O Routine prevention of allergic reactions.	
\subseteq			

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:
Omeprazole - Tab dispersible 20 mg	
INITIATION Prerequisites (tick box where appropriate)	
O Only for use in tube-fed patients	

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:
L-ornithine L-aspartate	

INITIATION

Prerequisites (tick box where appropriate)

()For patients with chronic hepatic encephalopathy who have not responded to treatment with, or are intolerant to lactulose, or where lactulose is contraindicated

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:
Rifaximin	
INITIATION	
Prerequisites (tick box where appropriate)	

 $m O\,$ For patients with hepatic encephalopathy despite an adequate trial of maximum tolerated doses of lactulose

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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Diazoxide	
INITIATION Prerequisites (tick box where appropriate)	
m O For patients with confirmed hypoglycaemia caused by hyperinsulinis	m

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:
Dulaglutide	
INITIATION Prerequisites (tick box where appropriate)	
O For continuation only	

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:
Liraglutide	

or	0	For c	ontinuation use
•	and	0	Patient has type 2 diabetes
	and	0	Target HbA1c (of 53 mmol/mol or less) has not been achieved despite the regular use of all of the following funded blood glucose lowering agents for a period of least 6 months, where clinically appropriate: empagliflozin, metformin, and vildagliptin
			O Patient is Māori or any Pacific ethnicity*
		or	O Patient has pre-existing cardiovascular disease or risk equivalent (see note a)*
		or	O Patient has an absolute 5-year cardiovascular disease risk of 15% or greater according to a validated cardiovascular risk assessment calculator*
			O Patient has a high lifetime cardiovascular risk due to being diagnosed with type 2 diabetes during childhood or as a young adult*
		or	O Patient has diabetic kidney disease (see note b)*

Note: * Criteria intended to describe patients at high risk of cardiovascular or renal complications of diabetes.

- a) Pre-existing cardiovascular disease or risk equivalent defined as: prior cardiovascular disease event (i.e. angina, myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, transient ischaemic attack, ischaemic stroke, peripheral vascular disease), congestive heart failure or familial hypercholesterolaemia.
- Diabetic kidney disease defined as: persistent albuminuria (albumin:creatinine ratio greater than or equal to 3 mg/mmol, in at least two out of three b) samples over a 3-6 month period) and/or eGFR less than 60 mL/min/1.73m2 in the presence of diabetes, without alternative cause identified.
- Funded GLP-1a treatment is not to be given in combination with (empagliflozin / empagliflozin with metformin hydrochloride) unless receiving C) (empagliflozin or empagliflozin in combination with metformin hydrochloride) for the treatment of heart failure.

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:		

Empagliflozin; Empagliflozin with metformin hydrochloride

		heart failure reduced ejection fraction (tick boxes where appropriate)
)	Patient has heart failure
and and)	Patient is in NYHA functional class II or III or IV
	~	O Patient has a documented left ventricular ejection fraction (LVEF) of less than or equal to 40%
	or	O An ECHO is not reasonably practicable, and in the opinion of the treating practitioner the patient would benefit from treatment
and)	Patient is receiving concomitant optimal standard funded chronic heart failure treatment

INITIATION – Type 2 Diabetes

Prerequisites (tick boxes where appropriate)

	or	$\overline{\mathbf{O}}$		tinuation use
	or	U F	Patient	has previously had an initial approval for a GLP-1 agonist
		(and	Ор	atient has type 2 diabetes
			or (D Patient is Māori or any Pacific ethnicity*
				D Patient has pre-existing cardiovascular disease or risk equivalent (see note a)*
			or or	Patient has an absolute 5-year cardiovascular disease risk of 15% or greater according to a validated cardiovascular risk assessment calculator*
			or (Patient has a high lifetime cardiovascular risk due to being diagnosed with type 2 diabetes during childhood or as a young adult*
				Patient has diabetic kidney disease (see note b)*
		and		arget HbA1c (of 53 mmol/mol or less) has not been achieved despite the regular use of at least one blood-glucose lowering gent (e.g. metformin, vildagliptin, or insulin) for at least 3 months
No	te: * Cr	riteria i	ntende	d to describe patients at high risk of cardiovascular or renal complications of diabetes.
a)	corona	ry inte	rventio	ascular disease or risk equivalent defined as: prior cardiovascular disease event (i.e. angina, myocardial infarction, percutaneous n, coronary artery bypass grafting, transient ischaemic attack, ischaemic stroke, peripheral vascular disease), congestive heart percholesterolaemia.
b)				ase defined as: persistent albuminuria (albumin:creatinine ratio greater than or equal to 3 mg/mmol, in at least two out of three month period) and/or eGFR less than 60 mL/min/1.73m2 in the presence of diabetes, without alternative cause.
c)	Funded [empagliflozin / empagliflozin with metformin hydrochloride] treatment is not to be given in combination with a funded GLP-1 unless receiving (empagliflozin / empagliflozin with metformin hydrochloride] for the treatment of heart failure.			

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:				
Ursodeoxycholic acid	Jrsodeoxycholic acid				
INITIATION – Alagille syndrome or progressive familial intrahepatic cho Prerequisites (tick boxes where appropriate)	lestasis				
O Patient has been diagnosed with Alagille syndrome or O Patient has progressive familial intrahepatic cholestasis					
INITIATION – Chronic severe drug induced cholestatic liver injury Prerequisites (tick boxes where appropriate)					
O Patient has chronic severe drug induced cholestatic liver inju	у				
Cholestatic liver injury not due to Total Parenteral Nutrition (T and	PN) use in adults				
O Treatment with ursodeoxycholic acid may prevent hospital ad	mission or reduce duration of stay				
INITIATION – Primary biliary cholangitis Prerequisites (tick boxes where appropriate)					
O Primary biliary cholangitis confirmed by antimitochondrial ant without raised serum IgM or, if AMA is negative by liver biops and	ibody titre (AMA) > 1:80, and raised cholestatic liver enzymes with or y				
O Patient not requiring a liver transplant (bilirubin > 100 umol/l;	decompensated cirrhosis				
INITIATION – Pregnancy Prerequisites (tick box where appropriate)					
O Patient diagnosed with cholestasis of pregnancy					
INITIATION – Haematological transplant Prerequisites (tick boxes where appropriate)					
O Patient at risk of veno-occlusive disease or has hepatic impacell or bone marrow transplantation	rment and is undergoing conditioning treatment prior to allogenic stem				
O Treatment for up to 13 weeks					
INITIATION – Total parenteral nutrition induced cholestasis Prerequisites (tick boxes where appropriate)					
O Paediatric patient has developed abnormal liver function as in and	ndicated on testing which is likely to be induced by TPN				
O Liver function has not improved with modifying the TPN comp	position				
INITIATION – prevention of sinusoidal obstruction syndrome Prerequisites (tick box where appropriate)					
The individual has leukaemia/lymphoma and requires prophylaxis for medications/therapies with a high risk of sinusoidal obstruction syndrome					

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:		
Methylnaltrexone bromide			
NITIATION – Opioid induced constipation			
Prerequisites (tick boxes where appropriate)			

and	0	The	patient is receiving palliative care	
		Ο	Oral and rectal treatments for opioid induced constipation are ineffective	
	or	Ο	Oral and rectal treatments for opioid induced constipation are unable to be tolerated	

INITIATION – Opioid induced constipation outside of palliative care

Re-assessment required after 14 days

 $\label{eq:prerequisites} \textbf{Prerequisites} \ (tick \ boxes \ where \ appropriate)$

and and

Individual has opioid induced constipation

Oral and rectal treatments for opioid induced constipation, including bowel-cleansing preparations, are ineffective or inappropriate

Mechanical bowel obstruction has been excluded

I confirm that the above details are correct:

Signed: Date:

and ()

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	PATIENT:		
Name:	Name:		
Ward:	NHI:		
sodium picosulfate			
INITIATION Prerequisites (tick boxes where appropriate)			

O The patient is a child with problematic constipation despite an adequate trial of other oral pharmacotherapies including macrogol where practicable

The patient would otherwise require a high-volume bowel cleansing preparation

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:		Name:		
Ward:		NHI:		

Betaine

()

(
	ATIO			a factor de la contra
				quired after 12 months
Prer	equis	ites	(tick	k boxes where appropriate)
and			cribe Iospi	ed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health ital.
	(and	О	The	e patient has a confirmed diagnosis of homocystinuria
		or	0	A cystathionine beta-synthase (CBS) deficiency
			\bigcirc	A 5,10-methylene-tetrahydrofolate reductase (MTHFR) deficiency
		or	О	A disorder of intracellular cobalamin metabolism
	and	О	An	appropriate homocysteine level has not been achieved despite a sufficient trial of appropriate vitamin supplementation
	TINU. ssess			quired after 12 months

Prerequisites (tick box where appropriate)

O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

The treatment remains appropriate and the patient is benefiting from treatment

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:
Levocarnitine	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a neurologist, metabolic physician or metabolic disorders dietitian, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:		
Sodium phenylbutyrate			
INITIATION Re-assessment required after 12 months			
Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
and O For the chronic management of a urea cycle disorder involving a deficiency of carbamylphosphate synthetase, ornithine transcarbamylase or			

argininosuccinate synthetase

CONTINUATION

()

and \bigcirc

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

The treatment remains appropriate and the patient is benefiting from treatment

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:
Biotin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a metabolic physician or metabolic disorders dietitian, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:		
Pyridoxal-5-phosphate			

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a neurologist, metabolic physician or metabolic disorders dietitian, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	

Galsulfase

and

Re-a Prer	equis F	N ment required after 12 months ites (tick boxes where appropriate) Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health IZ Hospital.
and	and	O The patient has been diagnosed with mucopolysaccharidosis VI
		O Diagnosis confirmed by demonstration of N-acetyl-galactosamine-4-sulfatase (arylsulfatase B) deficiency confirmed by either enzyme activity assay in leukocytes or skin fibroblasts
		O Detection of two disease causing mutations and patient has a sibling who is known to have mucopolysaccharidosis VI
Re-a	ssess	ATION ment required after 12 months ites (tick boxes where appropriate)
and		Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health IZ Hospital.
	and	O The treatment remains appropriate for the patient and the patient is benefiting from treatment
		Patient has not had severe infusion-related adverse reactions which were not preventable by appropriate pre-medication and/or adjustment of infusion rates
	and	Patient has not developed another life threatening or severe disease where the long term prognosis is unlikely to be influenced by Enzyme Replacement Therapy (ERT)

Patient has not developed another medical condition that might reasonably be expected to compromise a response to ERT

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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:

Alglucosidase Alfa

INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and () The patient is aged up to 24 months at the time of initial application and has been diagnosed with infantile Pompe disease and () Diagnosis confirmed by documented deficiency of acid alpha-glucosidase by prenatal diagnosis using chorionic villus biopsies and/or cultured amniotic cells or Documented deficiency of acid alpha-glucosidase, and urinary tetrasaccharide testing indicating a diagnostic elevation of glucose tetrasaccharides or Documented deficiency of acid alpha-glucosidase, and documented molecular genetic testing indicating a disease-causing mutation in the acid alpha-glucosidase gene (GAA gene) or Documented urinary tetrasaccharide testing indicating a diagnostic elevation of glucose tetrasaccharides, and molecular genetic testing indicating a disease-causing mutation in the GAA gene and) Patient has not required long-term invasive ventilation for respiratory failure prior to starting enzyme replacement therapy (ERT) and () Patient does not have another life-threatening or severe disease where the prognosis is unlikely to be influenced by ERT or might be reasonably expected to compromise a response to ERT and Alglucosidase alfa to be administered at doses no greater than 20 mg/kg every 2 weeks

Re-a		men	t required after 12 months (tick boxes where appropriate)
and			cribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.
	and	С	The treatment remains appropriate for the patient and the patient is benefiting from treatment
	and	С	Alglucosidase alfa to be administered at doses no greater than 20 mg/kg every 2 weeks
	(С	Patient has not had severe infusion-related adverse reactions which were not preventable by appropriate pre-medication and/or adjustment of infusion rates
	and (С	Patient has not developed another life threatening or severe disease where the long term prognosis is unlikely to be influenced by ERT
	and (and	С	Patient has not developed another medical condition that might reasonably be expected to compromise a response to ERT
	(С	There is no evidence of life threatening progression of respiratory disease as evidenced by the needed for > 14 days of invasive ventilation
	and (С	There is no evidence of new or progressive cardiomyopathy

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:

Idursulfase

Re-a		men	nt required after 24 weeks (tick boxes where appropriate)	
(and	O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
	(and	O The patient has been diagnosed with Hunter Syndrome (mucopolysacchardosis II)		
		or	 Diagnosis confirmed by demonstration of iduronate 2-sulfatase deficiency in white blood cells by either enzyme assay in cultured skin fibroblasts Detection of a disease causing mutation in the iduronate 2-sulfatase gene 	
and O Patient is going to proceed with a haematopoietic stem cell transplant (HSCT) within the next 3 months and would be bridging treatment to transplant		Patient is going to proceed with a haematopoietic stem cell transplant (HSCT) within the next 3 months and treatment with idursulfase would be bridging treatment to transplant		
an	(and (С С	Patient has not required long-term invasive ventilation for respiratory failure prior to starting Enzyme Replacement Therapy (ERT) Idursulfase to be administered for a total of 24 weeks (equivalent to 12 weeks pre- and 12 weeks post-HSCT) at doses no greater than 0.5 mg/kg every week	

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:

Laronidase

			required after 24 weeks
			ick boxes where appropriate)
(and			bed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health spital.
	and	0	The patient has been diagnosed with Hurler Syndrome (mucopolysacchardosis I-H)
		or	O Diagnosis confirmed by demonstration of alpha-L-iduronidase deficiency in white blood cells by either enzyme assay in cultured skin fibroblasts
	O Detection of two disease causing mutations in the alpha-L-iduronidase gene and patient has a sibling who is known to hav Hurler syndrome		O Detection of two disease causing mutations in the alpha-L-iduronidase gene and patient has a sibling who is known to have Hurler syndrome
	and	0	Patient is going to proceed with a haematopoietic stem cell transplant (HSCT) within the next 3 months and treatment with laronidase vould be bridging treatment to transplant
	and	0	Patient has not required long-term invasive ventilation for respiratory failure prior to starting Enzyme Replacement Therapy (ERT)
		0	aronidase to be administered for a total of 24 weeks (equivalent to 12 weeks pre- and 12 post-HSCT) at doses no greater than 00 units/kg every week

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:	

Taliglucerase alfa

INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and () The patient has a diagnosis of symptomatic type 1 or type 3* Gaucher disease confirmed by the demonstration of specific deficiency of glucocerebrosidase in leukocytes or cultured skin fibroblasts, and genotypic analysis and Patient does not have another life-threatening or severe disease where the prognosis is unlikely to be influenced by enzyme replacement therapy (ERT) or the disease might be reasonably expected to compromise a response to ERT and \bigcirc Patient has haematological complications of Gaucher disease or Patient has skeletal complications of Gaucher disease or Patient has significant liver dysfunction or hepatomegaly attributable to Gaucher disease or Patient has reduced vital capacity from clinically significant or progressive pulmonary disease due to Gaucher disease or Patient is a child and has experienced growth failure with significant decrease in percentile linear growth over a 6-12 month period and Taliglucerase alfa is to be administered at a dose no greater than 30 unit/kg every other week rounded to the nearest whole vial (200 units) Note: Indication marked with * is an unapproved indication CONTINUATION Re-assessment required after 3 years Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a metabolic physician or any relevant practitioner on the recommendation of a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and () Patient has demonstrated a symptomatic improvement and has maintained improvements in the main symptom or symptoms for which therapy was started and Patient has demonstrated a clinically objective improvement or no deterioration in haemoglobin levels, platelet counts and liver and spleen size and RRadiological (MRI) signs of bone activity performed at two years since initiation of treatment, and five yearly thereafter, demonstrate no deterioration shown by the MRI, compared with MRI taken immediately prior to commencement of therapy or adjusted dose and Patient has not developed another medical condition that might reasonably be expected to compromise a response to ERT and Patient is adherent with regular treatment and taliglucerase alfa is to be administered at a dose no greater than 30 unit/kg every other week rounded to the nearest whole vial (200 units)

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:

Sapropterin dihydrochloride

INITIATION Re-assessment required after 1 month Prerequisites (tick boxes where appropriate)		
O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Healt NZ Hospital.		
O Patient has phenylketonuria (PKU) and is pregnant or actively planning to become pregnant		
and O Treatment with sapropterin is required to support management of PKU during pregnancy and		
O Sapropterin to be administered at doses no greater than a total daily dose of 20 mg/kg		
O Sapropterin to be used alone or in combination with PKU dietary management		
Total treatment duration with sapropterin will not exceed 22 months for each pregnancy (includes time for planning and becoming pregnant) and treatment will be stopped after delivery		
Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Healt NZ Hospital. and		
 Following the initial one-month approval, the patient has demonstrated an adequate response to a 2 to 4 week trial of sapropterin with a clinically appropriate reduction in phenylalanine levels to support management of PKU during pregnancy On subsequent renewal applications, the patient has previously demonstrated response to treatment with sapropterin and maintained adequate phenylalanine levels to support management of PKU during pregnancy 		
and O Patient continues to be pregnant and treatment with sapropterin will not continue after delivery		
or O Patient is actively planning a pregnancy and this is the first renewal for treatment with sapropterin or		
O Treatment with sapropterin is required for a second or subsequent pregnancy to support management of their PKU during pregnancy		
and O Sapropterin to be administered at doses no greater than a total daily dose of 20 mg/kg and O Sapropterin to be used alone or in combination with PKU dietary management and		
O Total treatment duration with sapropterin will not exceed 22 months for each pregnancy (includes time for planning and becoming pregnant) and treatment will be stopped after delivery		

and

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	PATIENT:
Name:	Name:
Ward:	NHI:
Carglumic Acid	
INITIATION Prerequisites (tick box where appropriate)	

()Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

O For the acute in-patient treatment of organic acidaemias as an alternative to haemofiltration

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:	
Coenzyme Q10		
INITIATION Re-assessment required after 6 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O The patient has a suspected inborn error of metabolism that may respond to coenzyme Q10 supplementation		
CONTINUATION Re-assessment required after 24 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a metabolic physician, or in acco NZ Hospital. and O The patient has a confirmed diagnosis of an inborn error of me and O The treatment remains appropriate and the patient is benefitin		

I confirm that the above details are correct:

Signed: Date:

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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:
Riboflavin	
INITIATION Re-assessment required after 6 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a metabolic physician or neuroloc by the Health NZ Hospital. and O The patient has a suspected inborn error of metabolism that may restrict the patient has a suspected inborn error of metabolism that may restrict the patient has a suspected inborn error of metabolism that may restrict the patient has a suspected inborn error of metabolism that may restrict the patient has a suspected inborn error of metabolism that may restrict the patient has a suspected inborn error of metabolism that may restrict the patient has a suspected inborn error of metabolism that may restrict the patient has a suspected inborn error of metabolism that may restrict the patient has a suspected inborn error of metabolism that may restrict the patient has a suspected inborn error of metabolism that may restrict the patient has a suspected inborn error of metabolism that may restrict the patient has a suspected inborn error of metabolism that may restrict the patient has a suspected inborn error of metabolism that may restrict the patient has a suspected inborn error of metabolism that may restrict the patient has a suspected inborn error of metabolism that may restrict the patient has a suspected inborn error of metabolism that may restrict the patient has a suspected inborn error of metabolism that may restrict the patient has a suspected inborn error of metabolism that may restrict the patient has a suspected inborn error of metabolism that may restrict the patient has a suspected inborn error of metabolism the patient has a suspected inborn error of metabolism the patient has a suspected inborn error of metabolism the patient has a suspected inborn error of metabolism the patient ha	gist, or in accordance with a protocol or guideline that has been endorsed spond to riboflavin supplementation
CONTINUATION Re-assessment required after 24 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a metabolic physician or neurold by the Health NZ Hospital. and O The patient has a confirmed diagnosis of an inborn error of me and O The treatment remains appropriate and the patient is benefiting	

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.

Name: Name: Ward: NHI: Taurine NHI: INITIATION Re-assessment required after 6 months Prerequisites (tick box where appropriate) Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and The patient has a suspected specific mitochondrial disorder that may respond to taurine supplementation CONTINUATION Re-assessment required after 24 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O The patient has a confirmed diagnosis of a specific mitochondrial disorder which responds to taurine supplementation	PRESCRIBER	PATIENT:
Taurine INITIATION Re-assessment required after 6 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O The patient has a suspected specific mitochondrial disorder that may respond to taurine supplementation CONTINUATION Re-assessment required after 24 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O The patient has a confirmed diagnosis of a specific mitochondrial disorder which responds to taurine supplementation	Name:	Name:
INITIATION Re-assessment required after 6 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O The patient has a suspected specific mitochondrial disorder that may respond to taurine supplementation CONTINUATION Re-assessment required after 24 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O The patient has a confirmed diagnosis of a specific mitochondrial disorder which responds to taurine supplementation	Ward:	NHI:
Re-assessment required after 6 months Prerequisites (tick box where appropriate) Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. The patient has a suspected specific mitochondrial disorder that may respond to taurine supplementation CONTINUATION Re-assessment required after 24 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. The patient has a suspected specific mitochondrial disorder that may respond to taurine supplementation CONTINUATION Re-assessment required after 24 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and The patient has a confirmed diagnosis of a specific mitochondrial disorder which responds to taurine supplementation	Taurine	
Re-assessment required after 24 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O The patient has a confirmed diagnosis of a specific mitochondrial disorder which responds to taurine supplementation	Re-assessment required after 6 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a metabolic physician, or in acco NZ Hospital. and	
O The treatment remains appropriate and the patient is benefiting from treatment		

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:
Trientine	
and Treatment with zinc has been trialled and discontinued becau	nued because the person has experienced intolerable side effects or has use the person has experienced intolerable side effects or has not ppropriate as the person has symptomatic liver disease and requires

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.

PRES	CRIBER		PATIENT:
Name):		Name:
Ward:			NHI:
Сорр	per chlo	oride	
Re-a	ssessme	Moderate to severe burns nt required after 3 months (tick boxes where appropriate)	
	and	Patient has been hospitalised with moderate to severe burns	
		Treatment is recommended by a National Burns Unit specialist	

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:
Ferric carboxymaltose	
INITIATION Prerequisites (tick box where appropriate)	
O Treatment with oral iron has proven ineffective or is clinically inappro	ppriate

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.

PRES	CRIBER	PATIENT:
Name		Name:
Ward		NHI:
Sele	nium	
	ATION – Moderate to severe burns ssessment required after 3 months	
Prer	equisites (tick boxes where appropriate)	
	O Patient has been hospitalised with moderate to severe burns	
	O Treatment is recommended by a National Burns Unit specialis	t

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:	
Sodium hyaluronate		

INITIATION

Prerequisites (tick box 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.

I confirm that the	above details	are correct:
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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.

PRES	CRI	BER		PATIENT:
Name	:			Name:
Ward				NHI:
Mult	ivita	amir	is - Cap	
INITI Prer			(tick boxes where appropriate)	
		Ο	Patient has cystic fibrosis with pancreatic insufficiency	
	or	Ο	Patient is an infant or child with liver disease or short gut synd	rome
	or	0	Patient has severe malabsorption syndrome	
\subseteq				

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:
Multivitamins – Powder	
INITIATION Prerequisites (tick box where appropriate)	
O Patient has inborn errors of metabolism	

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.

PRES	CRIB	ER			PATIENT:
Name	:				Name:
Ward:					NHI:
Multi	vita	min	and	l mineral supplement	
	ssess	men ites	(tick b	ired after 3 months boxes where appropriate) ant was admitted to hospital with burns	
		or or	0 0	Burn size is greater than 15% of total body surface area Burn size is greater than 10% of BSA for mid-dermal or o	
			0	Nutritional status prior to admission or dietary intake is p	oor

or

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	PATIENT:
Name:	Name:
Ward:	NHI:
Multivitamin renal	
INITIATION Prerequisites (tick boxes where appropriate)	

 \bigcirc The patient has chronic kidney disease and is receiving either peritoneal dialysis or haemodialysis

The patient has chronic kidney disease grade 5, defined as patient with an estimated glomerular filtration rate of < 15 ml/min/1.73m² body surface area (BSA)

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.

PRESCRI	IBER	PATIENT:
Name:		
Ward:		
Alpha to	осор	oheryl acetate
		Cystic fibrosis (tick boxes where appropriate)
and	O d	Cystic fibrosis patient
	or	O Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck)
		O The other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate for the patient
Prerequi	isites	Osteoradionecrosis (tick box where appropriate) he treatment of osteoradionecrosis
		Other indications (tick boxes where appropriate)
and	O	Infant or child with liver disease or short gut syndrome
and	Ο	Requires vitamin supplementation
	or	O Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplements (Vitabdeck)
		O The other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate for patient

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:

Alpha tocopheryl

		Cystic fibrosis (tick boxes where appropriate)
(and	С	Cystic fibrosis patient
	or	O Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck)
		O The other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate for the patient
 quisi	ites	Osteoradionecrosis (tick box where appropriate) ne treatment of osteoradionecrosis
 		Other indications (tick boxes where appropriate)
(and	С	Infant or child with liver disease or short gut syndrome
and (С	Requires vitamin supplementation
	or	O Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplements (Vitabdeck)
		O The other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate for patient

Blood and Blood Forming Organs

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:		

Epoetin beta

and) Patie	nt in chronic renal failure
and) Haer	noglobin is less than or equal to 100g/L
	an	 Patient does not have diabetes mellitus Glomerular filtration rate is less than or equal to 30ml/min
	or an	 Patient has diabetes mellitus Glomerular filtration rate is less than or equal to 45ml/min

INITIATION – myelodysplasia*

and

and

and

and

Re-assessment required after 12 months

 $\label{eq:precession} \textbf{Prerequisites} \ (tick \ boxes \ where \ appropriate)$

\bigcirc	Patient has a confirmed diagnosis of myelodysplasia	(MDS)
and		

Has had symptomatic anaemia with haemoglobin < 100g/L and is red cell transfusion-dependent

O Patient has very low, low or intermediate risk MDS based on the WHO classification-based prognostic scoring system for myelodysplastic syndrome (WPSS)

 $\odot~$ Other causes of anaemia such as B12 and folate deficiency have been excluded

 ${\sf O}$ Patient has a serum epoetin level of < 500 IU/L

The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week

CONTINUATION – myelodysplasia*

Re-assessment required after 2 months
Prerequisites (tick boxes where appropriate)

O The patient's transfusion requirement continues to be reduced with epoetin treatment and

O Transformation to acute myeloid leukaemia has not occurred

The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week

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:
Epoetin beta - continued	
INITIATION – all other indications Prerequisites (tick boxes where appropriate)	
A Haematologist	
\bigcirc For use in patients where blood transfusion is not a viable trea	tment alternative
And	

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:						

Epoetin alfa

C	Patient in	chronic renal failure
and and) Haemogle	obin is less than or equal to 100g/L
	and	Patient does not have diabetes mellitus Glomerular filtration rate is less than or equal to 30ml/min
	or and	Patient has diabetes mellitus Glomerular filtration rate is less than or equal to 45ml/min

INITIATION – myelodysplasia*

and

and

and

and

and

and

Re-assessment required after 2 months

Prerequisites (tick boxes where appropriate)

(\bigcirc	Patient has a confirmed diagnosis of myelodysplasia (MDS
	\sim	i allent has a commed diagnosis of myclodysplasia	INIDO.

Has had symptomatic anaemia with haemoglobin < 100g/L and is red cell transfusion-dependent

\bigcirc	Patient has very low, low or intermediate risk MDS based on the WHO classification-based prognostic scoring system for myelodysplastic
	syndrome (WPSS)

 ${\cal J}\,$ Other causes of anaemia such as B12 and folate deficiency have been excluded

 ${\sf O}$ Patient has a serum epoetin level of < 500 IU/L

The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week

CONTINUATION – myelodysplasia*

Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

O The patient's transfusion requirement continues to be reduced with epoetin treatment and

O Transformation to acute myeloid leukaemia has not occurred

The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week

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:				
Epoetin alfa - continued					
INITIATION – all other indications					
Prerequisites (tick box 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.					
O For use in patients where blood transfusion is not a viable treatment Note: Indications marked with * are unapproved indications	alternative				

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.

PRES	SCR	BER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Apro	otin	in		
INITI Prer (Preso	(tick boxes where appropriate) cribed by, or recommended by a cardiac anaesthetist, or in according on the second second second second second	ordance with a protocol or guideline that has been endorsed by the Health
and		0	Paediatric patient undergoing cardiopulmonary bypass procec	lure
	or	0	Adult patient undergoing cardiac surgical procedure where the effects of the drug	e significant risk of massive bleeding outweighs the potential adverse

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.

PRES	CRI	BER											PAT	IENT:												
Name	:												Nar	ne:												
Ward:													NHI	:												
Eltro	mb	opa	g																							
Re-a	sses	smen sites	t requ (tick b cribed ital.	uired a boxes I by, or	ter 6 v vhere recom	reeks approp mende	oriate) ed by a	1 haem	-	-	in acco	-	ce wit	h a pr	otocol	l or gu	uidelir	ne that	: has b	been e	endors	ed by	r the H	ealth N	IZ	
	and	Ο				-	ectomy e thera		ave be	een tria	alled ar	nd faile	ed aft	er thei	rapy o	of 3 m	onths	each	(or 1 r	nonth	for rit	uxima	ab)			
		or	0 0 0	Patie	nt has	a plate	elet cou	unt of	less th	nan or),000 pla equal to equal to	o 20,0	000 pl	atelets	s per r	microl	litre a							bleedii	ng	
Re-a	sses	ssmen sites Preso Hosp	t requ (tick b cribed ital.	uired a box wh I by, or	ter 6 v ere ap recom	veeks propria mende	ate) ed by a	ı haem	natolog	gist, or	tion fo	ordan	ce wit	h a pr	otocol	l or gu	uidelir	ne that	has b	een e	endors	ed by	/ the H	ealth N	IZ	
Re-a Prero (and	sses equi C	ssmen sites Preso Hosp The p treatr	t requ (tick k cribed ital. patient nent is	uired a box wh I by, or It has d is requ	ter 12 ere ap recom btaine red	month propria mende d a res	s ate) ed by a sponse	haem (see	natolog Note)	gist, or from tr	rin acco reatmer 30,000	ordan nt duri	ce wit	e initia	al appr										IZ	
Re-a	sses	smen sites	t requ (tick b cribed	uired a boxes	ter 3 n	nonths approp	oriate)				dicated		-	-		l or gu	uidelir	ne that	: has b	een e	endors	ed by	/ the H	ealth N	IZ	
	and	Ο		immur Patie Patie	osupp nt has nt has	ressive immur immur	e thera	pies h mbocy mbocy	ave be	een tria	ontraind alled ar pura* w pura* w	nd faile vith a p	ed aft platele	er thei	rapy o	of 3 m ess th	onths nan or	each equal	(or 1 r	,000 p	olatele	ts pe	r micro		nt	

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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Eltrombopag - continued	
CONTINUATION – idiopathic thrombocytopenic purpura contraindicated Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	ce with a protocol or guideline that has been endorsed by the Health NZ ins e initial approval period elets per microlitre on treatment
Hospital. and O Two immunosuppressive therapies have been trialled and faile and O Patient has severe aplastic anaemia with a platelet course	
and Hospital.	ce with a protocol or guideline that has been endorsed by the Health NZ st 20,000 platelets per microlitre above baseline during the initial approval during the initial approval period

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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Aluminium chloride	
INITIATION Prerequisites (tick box where appropriate)	
O For use as a haemostatis agent	

and ()

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	PATIENT:
Name:	Name:
Ward:	NHI:
Emicizumab	

INITIATION - Severe Haemophilia A with or without FVIII inhibitors

Prerequisites (tick boxes where appropriate)

()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

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 3 mg/kg weekly for 4 weeks followed by the equivalent of 1.5 mg/kg weekly

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:						
Idarucizumab							

INITIATION

Prerequisites (tick box where appropriate)

()For the reversal of the anticoagulant effects of dabigatran when required in situations of life-threatening or uncontrolled bleeding, or for emergency surgery or urgent procedures

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:
Moroctocog alfa [Recombinant factor VIII]	

INITIATION

Prerequisites (tick box where appropriate)

For patients with haemophilia. Rare Clinical Circumstances Brand of short half-life recombinant factor VIII. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group, subject to criteria ()

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:
Octocog alfa [Recombinant factor VIII] (Advate)	

INITIATION

Prerequisites (tick box where appropriate)

()For patients with haemophilia. Preferred Brand of short half-life recombinant factor VIII. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group

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:
Octocog alfa [Recombinant factor VIII] (Kogenate FS)	

INITIATION

Prerequisites (tick box where appropriate)

For patients with haemophilia. Rare Clinical Circumstances Brand of short half-life recombinant factor VIII. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group, subject to criteria ()

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:
Nonacog gamma	

INITIATION

Prerequisites (tick box where appropriate)

()For patients with haemophilia. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group

I confirm that the	above details	are correct:
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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:
Rurioctocog alfa pegol [Recombinant factor VIII]	
)

INITIATION

Prerequisites (tick box where appropriate)

For patients with haemophilia A receiving prophylaxis treatment. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group ()

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:
Eftrenonacog alfa	

INITIATION

Prerequisites (tick box where appropriate)

For patients with haemophilia B receiving prophylaxis treatment. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group ()

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:
Factor eight inhibitor bypassing fraction	

INITIATION

Prerequisites (tick box where appropriate)

For patients with haemophilia. Preferred Brand of bypassing agent for > 14 days predicted use. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group ()

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:	
Eptacog alfa		

INITIATION

Prerequisites (tick box where appropriate)

()For patients with haemophilia. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group. Rare Clinical Circumstances Brand of bypassing agent for > 14 days predicted use. Access to funded treatment for > 14 days predicted use is by named patient application to the Haemophilia Treaters Group, subject to access criteria

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:
Bivalirudin	
INITIATION Prerequisites (tick boxes where appropriate)	
O For use in heparin-induced thrombocytopaenia, heparin resistance or heparin intolerance	
O For use in patients undergoing endovascular procedures	

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:
Danaparoid	
INITIATION Prerequisites (tick box where appropriate)	

O For use in heparin-induced thrombocytopaenia, heparin resistance or heparin intolerance

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.

PRESCR	IBER	PATIENT:
Name:		Name:
Ward:		NHI:
Defibro	tide	
INITIATION Prerequisites (tick box where appropriate)		
0	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	Patient has moderate or severe sinusoidal obstruction syndrome as	a result of chemotherapy or regimen-related toxicities

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:
Fondaparinux sodium	
INITIATION Prerequisites (tick box where appropriate)	

O For use in heparin-induced thrombocytopaenia, heparin resistance or heparin intolerance

and ()

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	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Lysine acetylsalicylate			
Prerequisites (tick boxes where appropriate)			

 \bigcirc For use when an immediate antiplatelet effect is required prior to an urgent interventional neuro-radiology or interventional cardiology procedure

Administration of oral aspirin would delay the procedure

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	ł	PATIENT:
Name:		Name:
Ward:		NHI:
Eptifibatide		
INITIATION Prerequisites or or or	s (tick boxes where appropriate) For use in patients with acute coronary syndromes undergoing For use in patients with definite or strongly suspected intra-cor For use in patients undergoing intra-cranial intervention	

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.

PRE	SCRI	BER			PATIENT:
Name:					Name:
Ward	:				NHI:
Tica	gre	lor			
	0	sites Rest an S	ricted	to trea ation c	nere appropriate) atment of acute coronary syndromes specifically for patients who have recently (within the last 60 days) been diagnosed with or a non-ST-elevation acute coronary syndrome, and in whom fibrinolytic therapy has not been given in the last 24 hours and
Re-a	asses	smer	nt requ	ired a	e prevention neurological stenting fter 12 months where appropriate)
		or	0		ent has had a neurological stenting procedure* in the last 60 days ent is about to have a neurological stenting procedure performed*
	and	d or	0	Patie	ent has demonstrated clopidogrel resistance using the P2Y12 (VerifyNow) assay or another appropriate platelet function y and requires antiplatelet treatment with ticagrelor
			or	0 0	Clopidogrel resistance has been demonstrated by the occurrence of a new cerebral ischemic event Clopidogrel resistance has been demonstrated by the occurrence of transient ischemic attack symptoms referable to the stent.
Re-a	asses	sites	nt requ (tick t Patie	ired at boxes v ent is c	bosis prevention neurological stenting fter 12 months where appropriate) continuing to benefit from treatment continues to be clinically appropriate
Re-a	asses	smer	nt requ	ired at	tus coronary intervention with stent deployment fter 12 months where appropriate)
	and and	Ο	Patie	ent has	s undergone percutaneous coronary intervention s had a stent deployed in the previous 4 weeks clopidogrel-allergic**
		sites	(tick b	box wh	nbosis nere appropriate) rienced cardiac stent thrombosis whilst on clopidogrel
Re-a	asses	smer sites	nt requ (tick b	ired at	infarction fter 1 week here appropriate) se while in hospital following ST-elevated myocardial infarction
L conf	irm tł				ails 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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:

Ticagrelor - continued

Note: Indications marked with * are unapproved indications. Note: Note: ** Clopidogrel allergy is defined as a history of anaphylaxis, urticaria, generalised rash or asthma (in non-asthmatic patients) developing soon after clopidogrel is started and is considered unlikely to be caused by any other treatment

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	RIBE	ER		PATIENT:
Name:				Name:
Ward:				NHI:
Plerix	afor	•		
Re-ass	sessn	nent r	equire	bus stem cell transplant d after 3 days es where appropriate)
and		rescrik ospita		, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
Patient is to undergo stem cell transplantation And Patient has not had a previous unsuccessful mobilisation attempt with plerixafor and				
			(and	 Patient is undergoing G-CSF mobilisation O Has a suboptimal peripheral blood CD34 count of less than or equal to 10 × 10⁶/L on day 5 after 4 days of G-CSF treatment O Efforts to collect > 1 × 10⁶ CD34 cells/kg have failed after one apheresis procedure
		or	and	Patient is undergoing chemotherapy and G-CSF mobilisation O Has rising white blood cell counts of > 5 × 10 ⁹ /L and O Has a suboptimal peripheral blood CD34 count of less than or equal to 10 × 10 ⁶ /L or O Efforts to collect > 1 × 10 ⁶ CD34 cells/kg have failed after one apheresis procedure or O previous mobilisation attempt with G-CSF or G-CSF plus chemotherapy has failed

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:		
Pegfilgrastim			

INITIATION

Prerequisites (tick box where appropriate)

O For prevention of neutropenia in patients undergoing high risk chemotherapy for cancer (febrile neutropenia risk greater than or equal to 5%*) Note: *Febrile neutropenia risk greater than or equal to 5% after taking into account other risk factors as defined by the European Organisation for Research and Treatment of Cancer (EORTC) guidelines

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:
Filgrastim	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a haematologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Sodium chloride – Inj	
INITIATION Prerequisites (tick box where appropriate)	
O For use in flushing of in-situ vascular access devices only	

Cardiovascular System

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.

PRES	SCRI	BER		PATIENT:
Name:			Name:	
Ward:				NHI:
Capt	opr	il - C	Dral liq 5 mg per ml	
INITI Prere			(tick boxes where appropriate)	
		Ο	For use in children under 12 years of age	
	or	Ο	For use in tube-fed patients	
	or	0	For management of rebound transient hypertension following	cardiac surgery

and

and \bigcirc

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.

PRES	SCRIB	ER			PATIENT:
Name	e:				Name:
Ward	:				NHI:
Sacı	ubitri	il wi	ith v	alsartan	
	IATIOI requis	ites		poxes where appropriate) ent has heart failure	
	and	or	0 0	Patient is in NYHA/WHO functional class II Patient is in NYHA/WHO functional class III	
		or	0	Patient is in NYHA/WHO functional class IV	

	Ο	Patient has a documented left ventricular ejection fraction (LVE	F) of les	ss than	or equal	to 35%	
or							

An ECHO is not reasonably practical, and in the opinion of the treating practitioner the patient would benefit from treatment ()

Patient is receiving concomitant optimal standard chronic heart failure treatments

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:				
Adenosine - Inj 3 mg per ml, 10 ml vial					
INITIATION Prerequisites (tick box where appropriate)					
O For use in cardiac catheterisation, electrophysiology and MRI					

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:		
Ajmaline			

Prerequisites (tick box where appropriate)

()Prescribed by, or recommended by a cardiologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

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.

PRES	SCRIB	ER		PATIENT:	
Name	e:			Name:	
Ward	:			NHI:	
Ivab	radir	ne			
	ATIOI equis		(tick boxes where appropriate)		
	(and	С	Patient is indicated for computed tomography coronary angiog	graphy	
	O Patient has a heart rate of greater than 70 beats per minute while taking a maximally tolerated dose of beta blocker				
O Patient is unable to tolerate beta blockers					

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:			
Midodrine				
INITIATION Prerequisites (tick box where appropriate)				
${ m O}~$ Patient has disabling orthostatic hypotension not due to drugs				

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:				
Nicardipine hydrochloride					

Prer			(tick boxes where appropriate)
(and	С		cribed by, or recommended by an anaesthetist, intensivist, cardiologist or paediatric cardiologist, or in accordance with a protocol or eline that has been endorsed by the Health NZ Hospital.
		Ο	Patient has hypertension requiring urgent treatment with an intravenous agent
	or O Patient has excessive ventricular afterload		
	or	Ο	Patient is awaiting or undergoing cardiac surgery using cardiopulmonary bypass

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.

PRES	CRIB	ER			PATIENT:
Name	:				Name:
Ward:					NHI:
Eplei	reno	ne			
INITI. Prere			(tick t	poxes where appropriate)	
	and	С	Patie	ent has heart failure with ejection fraction less than 40%	
			Ο	Patient is intolerant to optimal dosing of spironolactone	
		or	0	Patient has experienced a clinically significant adverse e	ffect while on optimal dosing of spironolactone

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:
Talvantan	

Tolvaptan

INITIATION - autosomal dominant polycystic kidney disease Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a renal physician or any relevant practitioner on the recommendation of a renal physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Patient has a confirmed diagnosis of autosomal dominant polycystic kidney disease and O Patient has an estimated glomerular filtration rate (eGFR) of greater than or equal to 25 ml/min/1.73 m² at treatment initiation or O Patient's disease is rapidly progressing, with a decline in eGFR of greater than or equal to 5 mL/min/1.73 m² within one-year or O Patient's disease is rapidly progressing, with an average decline in eGFR of greater than or equal to 2.5 mL/min/1.73 m² per year over a five-year period

CONTINUATION – autosomal dominant polycystic kidney disease Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a renal physician or any relevant practitioner on the recommendation of a renal physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Patient has not developed end-stage renal disease, defined as an eGFR of less than 15 mL/min/1.73 m² O Patient has not undergone a kidney transplant

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:

Rosuvastatin

INITIATION – cardiovascular disease risk Prerequisites (tick boxes where appropriate)				
	 Patient is considered to be at risk of cardiovascular disease Patient is Māori or any Pacific ethnicity 			
or	 Patient has a calculated risk of cardiovascular disease of at least 15% over 5 years LDL cholesterol has not reduced to less than 1.8 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or simvastatin 			
	nilial hypercholesterolemia Sk boxes where appropriate)			
and	atient has familial hypercholesterolemia (defined as a Dutch Lipid Criteria score greater than or equal to 6) DL cholesterol has not reduced to less than 1.8 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or mvastatin			
	ablished cardiovascular disease Sk boxes where appropriate)			
	 Patient has proven coronary artery disease (CAD) Patient has proven peripheral artery disease (PAD) Patient has experienced an ischaemic stroke 			
and	DL cholesterol has not reduced to less than 1.4 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or mvastatin			
	eurrent major cardiovascular events ek boxes where appropriate)			
and	atient has experienced a recurrent major cardiovascular event (defined as myocardial infarction, ischaemic stroke, coronary vascularisation, hospitalisation for unstable angina) in the last 2 years			

simvastatin

LDL cholesterol has not reduced to less than 1.0 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or

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:
Levosimendan	
INITIATION – Heart transplant Prerequisites (tick boxes where appropriate)	
O For use as a bridge to heart transplant, in patients who have b or O For the treatment of heart failure following heart transplant	been accepted for transplant
INITIATION – Heart failure Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a cardiologist or intensivist, or in Health NZ Hospital.	accordance with a protocol or guideline that has been endorsed by the

O For the treatment of severe acute decompensated heart failure that is non-responsive to dobutamine

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.

PATIENT:
Name:
NHI:

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.

PRES	SCR	IBER		PATIENT:			
Name:			Name:				
Ward:				NHI:			
Hydr	Hydralazine hydrochloride - Tab 25 mg						
INITI Prere			(tick boxes where appropriate)				
		0	For the treatment of refractory hypertension				
Or For the treatment of heart failure, in combination with a nitrate, in patients who are intolerant or have not responded to ACE and/or angiotensin receptor blockers				, in patients who are intolerant or have not responded to ACE inhibitors			

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:
bosentan	
INITIATION – PAH monotherapy Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
	gist, rheumatologist or any relevant practitioner on the recommendation of nce with a protocol or guideline that has been endorsed by the Health NZ
Patient has pulmonary arterial hypertension (PAH)*	

		O DALL has been confirmed by right boart apthetoriagtion	
	and	O PAH has been confirmed by right heart catheterisation	
	and	O A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair) and	
		O A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg	
	and	O Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵)	
		O PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †	
		O Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**	
		or O	
		O Patient has PAH other than idiopathic / heritable or drug-associated type	
	or	Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung	
	or	Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the second	
and	or ()	Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of t	
and	or ()	Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures	
and	or ()	Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures Bosentan is to be used as PAH monotherapy	

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	PATIE	NT:	
Name:	me: Name:		
Ward:	NHI:		
bosentan - ca	ntinued		
Re-assessment Prerequisites (O Presc	AH dual therapy required after 6 months ick boxes where appropriate) ibed by, or recommended by a respiratory specialist, cardiologist, rher ratory specialist, cardiologist or rheumatologist, or in accordance with al.	imatologist or any relevant practitioner on the recommendation of a protocol or guideline that has been endorsed by the Health NZ	
and and and	Patient has pulmonary arterial hypertension (PAH)* PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classificat PAH is in New York Heart Association/World Health Organization (NY		
and	defined in the 2022 ECS/ERS Guidelines for PAH (s	or equal to 15 mmHg or greater than 160 International Units (dyn s cm ⁻⁵) n vasoreactivity assessment using iloprost or nitric oxide, as ee note below for link to these guidelines) † e to calcium antagonist treatment, according to a validated	
or	 Patient is a child with PAH secondary to congenital heart diseas disorders including severe chronic neonatal lung disease Patient has palliated single ventricle congenital heart disease ar Fontan circulation requiring the minimising of pulmonary/venous 	d elevated pulmonary pressures or a major complication of the	
and	 Bosentan is to be used as part of PAH dual therapy Patient has tried a PAH monotherapy (sildenafil) for at lease therapeutic response to treatment according to a validated Patient is presenting in NYHA/WHO functional class III or benefit from initial dual therapy 	risk stratification tool**	

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.

PRES	CRIB	ER		PATIENT:
Name	:	Name:		
Ward:				NHI:
bose	entan) - coi	ntinue	d
INITI Re-a	ATION ssessi equisi D P a	N - PA ment r ites (ti Prescrit respin lospita	AH trip require ck bo bed by ratory al. Patient PAH is	 be therapy ad after 6 months kees where appropriate) y, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ has pulmonary arterial hypertension (PAH)* in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV PAH has been confirmed by right heart catheterisation A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair) A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm⁻⁵) O PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) † O Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**
	and	or (or (and		 Patient has PAH other than idiopathic / heritable or drug-associated type Patient has PAH other than idiopathic / heritable or drug-associated type Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung lisorders including severe chronic neonatal lung disease Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the contan circulation requiring the minimising of pulmonary/venous filling pressures Bosentan is to be used as part of PAH triple therapy Patient is on the lung transplant list Patient is presenting in NYHA/WHO functional class IV Patient has tried PAH dual therapy for at least three months and has not experienced an acceptable response to treatment according to a validated risk stratification tool** Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario

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.

PRESCRIBER		PATIENT:			
Name:		Name:			
Ward:		NHI:			
bosenta	an - continued				
CONTIN	UATION				
Re-asses	ssment required after 2 years				
Prerequi	isites (tick box where appropriate)				
O	Prescribed by, or recommended by a respiratory specialist, cardiolog a respiratory specialist, cardiologist or rheumatologist, or in accorda Hospital.	gist, rheumatologist or any relevant practitioner on the recommendation of nce with a protocol or guideline that has been endorsed by the Health NZ			
	and O Patient is continuing to derive benefit from bosentan treatment according to a validated PAH risk stratification tool**				

Note: † The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for th
diagnosis and treatment of pulmonary hypertension PAH
** the requirement to use a validated risk stratification tool to determine insufficient response applies to adult
Determining insufficient response in children does not require use of a validated PAH risk stratification tool, wher
currently no such validated tools exist for PAH risk stratification in children.

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:	

Ambrisentan

	INITIATION – PAH monotherapy Re-assessment required after 6 months				
Prer	equisi	ites (t	ick bo	exes where appropriate)	
(and	O Prescribed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
	(and	D f	Patient has pulmonary arterial hypertension (PAH)		
)	J f	PAH is	s in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications	
	and (and	O PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV			
			and	O PAH has been confirmed by right heart catheterisation	
				O A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)	
			anc	O A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg	
			and	O Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵)	
				O PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †	
				O Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**	
				O Patient has PAH other than idiopathic / heritable or drug-associated type	
		or or		Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease	
				Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures	
	and				
		and	O Ambrisentan is to be used as PAH monotherapy nd		
			O Patient has experienced intolerable side effects with both sildenafil and bosentan or		
			O Patient has an absolute contraindication to sildenafil and an absolute or relative contraindication to bosentan (e.g. due to current use of a combined oral contraceptive or liver disease)		
			or	O Patient is a child with idiopathic PAH or PAH secondary to congenital heart disease	
		\square	_	()	

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.

PRESCRIB	BER		PATIENT:
Name:			Name:
Ward:			NHI:
Ambrise	ntan	- cor	ntinued
Re-assess Prerequis	ites (1 Prescr a resp Hospit	requii tick bo ibed k iratory al. Patien PAH is	Hail therapy red after 6 months boxes where appropriate) by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of y specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ht has pulmonary arterial hypertension (PAH) is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
	or or	0	 A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair) A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm⁻⁵)
and	and	or	 Ambrisentan is to be used as PAH dual therapy Patient has tried a PAH monotherapy (sildenafil or bosentan) for at least three months and has not experienced an acceptable response to treatment according to a validated risk stratification tool** Patient has tried PAH dual therapy including bosentan and has experienced intolerable side effects on bosentan Patient is presenting in NYHA/WHO functional class III or IV, and in the opinion of the treating clinician would benefit from initial dual therapy Patient has an absolute or relative contraindication to bosentan (eg due to current use of a combined oral contraceptive or liver disease)

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.

ESCRIBER	PATIENT:
me:	Name:
ard:	NHI:
nbrisenta	n - continued
e-assessmer rerequisites O Pres	 PAH triple therapy nt required after 6 months (tick boxes where appropriate) cribed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of piratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ pital. Patient has pulmonary arterial hypertension (PAH) PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
or	O Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease
and	 Ambrisentan is to be used as PAH triple therapy Patient is on the lung transplant list Patient is presenting in NYHA/WHO functional class IV and Patient has an absolute or relative contraindication to bosentan (e.g. due to current use of a combined oral contraceptive or liver disease) Patient has tried PAH dual therapy for at least three months and remains in an unacceptable risk category according to a validated risk stratification tool** Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario

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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Ambrisentan - continued	
CONTINUATION Re-assessment required after 2 years Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a respiratory specialist, cardiolog a respiratory specialist, cardiologist or rheumatologist, or in accordan Hospital. and O The patient is continuing to derive benefit from ambrisentan treatme	gist, rheumatologist or any relevant practitioner on the recommendation of nce with a protocol or guideline that has been endorsed by the Health NZ nt according to a validated PAH risk stratification tool**
Note: † The European Respiratory Journal Guidelines can be found here: diagnosis and treatment of pulmonary hypertension PAH ** the requirement to use a validated risk stratification tool to determine ins Determining insufficient response in children does not require use of a validat currently no such validated tools exist for PAH risk stratification in children.	ufficient response applies to adults.

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:	

sildenafil (Vedafil)

	tablets Raynaud's Phenomenon (tick boxes where appropriate)
0	Patient has Raynaud's phenomenon
	Patient has severe digital ischaemia (defined as severe pain requiring hospital admission or with a high likelihood of digital ulceration; digital ulcers; or gangrene)
and O	Patient is following lifestyle management (proper body insulation, avoidance of cold exposure, smoking cessation support, avoidance of sympathomimetic drugs)
and	Patient has persisting severe symptoms despite treatment with calcium channel blockers and nitrates (unless contraindicated or not tolerated)
	tablets Pulmonary arterial hypertension (tick boxes where appropriate)

O Prescribed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and and and	 Patient has pulmonary arterial hypertension (PAH)* PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV 				
	PAH is confirmed by right heart catheterisation and A mean pulmonary artery pressure (PAPm) of greater than 20 mmHg and A pulmonary capillary wedge pressure (PCWP) that is less than or equal to 15 mmHg and Pulmonary vascular resistance (PVR) of at least 2 Wood Units or at least 160 International Units (dyn s cm ⁻⁵) and PAH is non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) † or Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**				
	or	 Patient has PAH other than idiopathic / heritable or drug-associated type Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures 			

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.

PRES	CRIB	ER		PATIENT:		
Name	:			Name:		
Ward				NHI:		
silde	enafil	(Ve	edafil) - continued			
			ablets other conditions (tick boxes where appropriate)			
	or (С	For use in weaning patients from inhaled nitric oxide			
	(or	\mathcal{O}	For perioperative use in cardiac surgery patients			
	(С	For use in intensive care as an alternative to nitric oxide			
or O For use in the treatment of erectile dysfunction secondary to spinal cord injury in patients being treated in a spinal unit						
			njection (tick boxes where appropriate)			
For use in the treatment of pulmonary hypertension in infants or children being treated in paediat intensive care units when the enteral route is not accessible				or children being treated in paediatric intensive care units and neonatal		
			O For perioperative use following cardiac surgery			
		or or	O For use in persistent pulmonary hypertension of the new	/born (PPHN)		
			O For use in congenital diaphragmatic hernia			

Note: † The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the diagnosis and treatment of pulmonary hypertension PAH ** the requirement to use a validated risk stratification tool to determine insufficient response applies to adults. Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where

currently no such validated tools exist for PAH risk stratification in children.

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:	

Epoprostenol

Re-a	sses	smen	t require	al therapy ed after 6 months kes where appropriate)	
and	;		biratory	y, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ	
	and		Patient has pulmonary arterial hypertension (PAH)		
	and	Ο	PAH is	in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications	
	and	Ο	PAH is	in New York Heart Association/World Health Organization (NYHA/WHO) functional class III or IV	
			(O PAH has been confirmed by right heart catheterisation	
			and (and	O A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)	
			and (O A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg	
			m O A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵)		
			und	O PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †	
				O Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**	
				O Patient has PAH other than idiopathic / heritable or drug-associated type	
		or or		Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung isorders including severe chronic neonatal lung disease	
				Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the contan circulation requiring the minimising of pulmonary/venous filling pressures	
	and		\bigcirc		
		and	а О р	poprostenol is to be used as part of PAH dual therapy with either sildenafil or an endothelin receptor antagonist Patient is presenting in NYHA/WHO functional class IV	
		and	Оr	Patient has tried a PAH monotherapy for at least three months and remains in an unacceptable risk category according to a alidated risk stratification tool	

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.	

PRES	PRESCRIBER			PATIENT:		
Name:	lame:					
Ward:						
Ерор	Epoprostenol - continued					
Re-as Prere	ssessm equisite D Pro a r	escrik respira ospita	equire ck box ped by atory I. atient AH is AH is	Ide therapy ad after 6 months kes where appropriate) v, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ has pulmonary arterial hypertension (PAH) in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications in New York Heart Association/World Health Organization (NYHA/WHO) functional class III or IV O PAH has been confirmed by right heart catheterisation		
			and (and (and (and	 A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair) A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm⁻⁵) PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) † Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool** Patient has PAH other than idiopathic / heritable or drug-associated type 		
		or or	d D F	Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung isorders including severe chronic neonatal lung disease Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the ontan circulation requiring the minimising of pulmonary/venous filling pressures		
		and	or or	 Patient is on the lung transplant list Patient is presenting in NYHA/WHO functional class IV Patient has tried PAH dual therapy for at least three months and has not experienced an acceptable response to treatment according to a validated risk stratification tool Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario 		

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:						
Epoprostenol - continued	Epoprostenol - continued						
a respiratory specialist, cardiologist or rheumatologist, or in accorda Hospital. and	gist, rheumatologist or any relevant practitioner on the recommendation of nce with a protocol or guideline that has been endorsed by the Health NZ						
O Patient is continuing to derive benefit from epoprostenol treatment according to a validated PAH risk stratification tool							
Note: † The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the							

diagnosis and treatment of pulmonary hypertension PAH ** the requirement to use a validated risk stratification tool to determine insufficient response applies to adults. Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

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.

PRESCRIE	BER	P	PATIENT:	
Name:		N	ame:	
Vard:		N	HI:	
oprost				
INITIATIO Re-assess Prerequis	DN – P sment sites (Presc a resp Hospi	piratory specialist, cardiologist or rheumatologist, or in accordance ital. Patient has pulmonary arterial hypertension (PAH) PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical class PAH is in New York Heart Association/World Health Organization O PAH has been confirmed by right heart catheterisatic and O A mean pulmonary artery pressure (PAPm) greater t and O A pulmonary capillary wedge pressure (PCWP) less and O A pulmonary vascular resistance greater than 2 Woo and O PAH has been demonstrated to be non-respon defined in the 2022 ECS/ERS Guidelines for P O Patient has not experienced an acceptable res risk stratification tool** O Patient has PAH other than idiopathic / heritable	n (NYHA/WHO) functional class II, III or IV nn han 20 mmHg (unless peri Fontan repair) than or equal to 15 mmHg d Units or greater than 160 International Units (dyn s cm ⁻⁵) sive in vasoreactivity assessment using iloprost or nitric oxide, as AH (see note below for link to these guidelines) † ponse to calcium antagonist treatment, according to a validated	
and	or	disorders including severe chronic neonatal lung disease O Patient has palliated single ventricle congenital heart disea Fontan circulation requiring the minimising of pulmonary/ve	se and elevated pulmonary pressures or a major complication of the enous filling pressures	
and	• 	O Iloprost is to be used as PAH monotherapy		
	and		Idenafil and both the funded endothelin receptor antagonists (i.e.	

O Patient has an absolute contraindication to sildenafil and an absolute or relative contraindication to endothelin receptor antagonists

or

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.

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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:	Ward: NHI:					
llopr	ost -	conti	inued			
INITI Re-a	ATION ssessi equisi P a	h - PA ment tes (t rescri respi lospita	AH trij requin ick bo ibed b ratory al. Patient PAH is	ed a xes y, or spe t has in (Fifter 6 wher r recc cialis s pulr A roup A rr A p A p	py imonths e appropriate) mmended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of t, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ nonary arterial hypertension (PAH) ot 1, 4 or 5 of the WHO (Venice 2003) clinical classifications York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV I has been confirmed by right heart catheterisation nean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair) ulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg ulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵) PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) † Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool** Patient has PAH other than idiopathic / heritable or drug-associated type
	and	or or and	0 0r 0	disorders i Patient has Fontan circ Illoprost is O Patie O Patie	a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung including severe chronic neonatal lung disease and elevated pulmonary pressures or a major complication of the culation requiring the minimising of pulmonary/venous filling pressures to be used as PAH triple therapy ent is on the lung transplant list ent is presenting in NYHA/WHO functional class IV Patient has tried PAH dual therapy for at least three months and has not experienced an acceptable response to treatment according to a validated risk stratification tool**	
						Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario

О

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	PATIENT:					
Name:	Name:					
Ward:	NHI:					
lloprost - continued						
CONTINUATION Re-assessment required after 2 years						
Prerequisites (tick box where appropriate)						
O Prescribed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.						

Patient is continuing to derive benefit from iloprost treatment according to a validated PAH risk stratification tool

Note: † The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the diagnosis and treatment of pulmonary hypertension PAH ** the requirement to use a validated risk stratification tool to determine insufficient response applies to adults. Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

Dermatologicals

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:		
Mafenide acetate			
INITIATION Prerequisites (tick box where appropriate)			
O For the treatment of burns patients			

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.

PRESCRIBE	3	PATIENT:
Name:		Name:
Ward:		NHI:
Betametha	sone valerate with clioquinol	
INITIATION Prerequisites	s (tick boxes where appropriate)	
	For the treatment of intertrigo	
or O	For continuation use	

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:
Pimecrolimus	

F	Prere	equisites (tick boxes where appropriate)
a	(and	O Prescribed by, or recommended by a dermatologist, paediatrician or ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
		O Patient has atopic dermatitis on the eyelid
		Patient has at least one of the following contraindications to topical corticosteroids: periorificial dermatitis, rosacea, documented epidermal atrophy, documented allergy to topical corticosteroids, cataracts, glaucoma, or raised intraocular pressure

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:
Terreliner Olerheimen	

Tacrolimus Ointment

(

INITIATION

and

Prerequisites (tick boxes where appropriate)

()Prescribed by, or recommended by a dermatologist or paediatrician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

 \bigcirc Patient has atopic dermatitis on the face and

Patient has at least one of the following contraindications to topical corticosteroids: periorificial dermatitis, rosacea, documented epidermal atrophy or documented allergy to topical corticosteroids

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:
Methyl aminolevulinate hydrochloride	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a dermatologist or plastic surgeon, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

Genito-Urinary System

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:
Terbutaline	

Prerequisites (tick box where appropriate)

()Prescribed by, or recommended by an obstetrician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

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.

PRES	CRIB	ER		PATIENT:
Name	:			Name:
Ward				NHI:
Fina	steri	de		
	ATION equisi		(tick boxes where appropriate)	
	(and	С	Patient has symptomatic benign prostatic hyperplasia	
		~	O The patient is intolerant of non-selective alpha blockers of	or these are contraindicated
		or	O Symptoms are not adequately controlled with non-select	ive alpha blockers

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:
Tamsulosin	
INITIATION Prerequisites (tick boxes where appropriate)	
O Patient has symptomatic benign prostatic hyperplasia	
The patient is intolerant of non-selective alpha blockers or the	ese are contraindicated

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.

PRES	CRIBER		PATIENT:
Name:	:		Name:
Ward:			NHI:
Potas	ssium o	citrate	
	ATION equisites	(tick boxes where appropriate)	
) and	The patient has recurrent calcium oxalate urolithiasis	
	0	The patient has had more than two renal calculi in the two yea	rs prior to the application

Hormone Preparations

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:
Oxandrolone - Tab 2.5 mg	
INITIATION Prerequisites (tick box where appropriate)	
O For the treatment of burns patients	

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.

PRESCR	BER	PATIENT:
Name:		Name:
Ward:		. NHI:
Cinacal	cet	
Re-asses	DN – parathyroid carcinoma or calciphylaxis ssment required after 6 months isites (tick boxes where appropriate) Prescribed by, or recommended by a nephrologist or endocrinolog the Health NZ Hospital.	ist, or in accordance with a protocol or guideline that has been endorsed by
	O The patient has been diagnosed with a parathyroid ca and O The patient has persistent hypercalcaemia (serum cal- treatments including sodium thiosulfate (where approp and O The patient is symptomatic	cium greater than or equal to 3 mmol/L) despite previous first-line
or	and	licific uraemic arteriolopathy) hypercalcaemia (serum calcium greater than or equal to 3 mmol/L) first-line treatments including bisphosphonates and sodium thiosulfate
	UATION – parathyroid carcinoma or calciphylaxis isites (tick boxes where appropriate) Prescribed by, or recommended by a nephrologist or endocrinolog the Health NZ Hospital.	ist, or in accordance with a protocol or guideline that has been endorsed by
an	 The patient's serum calcium level has fallen to < 3mmol/L The patient has experienced clinically significant symptom ir is does not include parathyroid adenomas unless these have become a series of the series of th	
	DN – primary hyperparathyroidism isites (tick boxes where appropriate)	
an an an	or O Patient has hypercalcaemia of more than 3 mmol/L w O Patient has hypercalcaemia of more than 2.85 mmol/L O Surgery is not feasible or has failed	. with symptoms

I confirm that the above details are correct:

Signed: Date:

 \bigcirc

or

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	PATIENT:
Name:	Name:
Ward:	NHI:
Cinacalcet - continued	
INITIATION – secondary or tertiary hyperparathyroidism Re-assessment required after 6 months	
Prerequisites (tick boxes where appropriate)	
O Patient has tertiary hyperparathyroidism and markedly er or O Patient has symptomatic secondary hyperparathyroidism	

and	O Residual parathyroid tissue has not been localised despite repeat unsuccessful parathyroid explorations or
	O Parathyroid tissue is surgically inaccessible
0	or O Parathyroid surgery is not feasible

The patient has had a kidney transplant, and following a treatment free interval of at least 12 weeks a clinically acceptable parathyroid hormone (PTH) level to support ongoing cessation of treatment has not been reached

The patient has not received a kidney transplant and trial of withdrawal of cinacalcet is clinically inappropriate

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:
Cabergoline	
INITIATION Prerequisites (tick boxes where appropriate) O Inhibition of lactation or O or O Patient has hyperprolactinemia or O Patient has acromegaly	
Note: Indication marked with * is an unapproved indication.	

RS1826 - Somatropin	
Prader-Willi syndrome - INITIATION	126
Prader-Willi syndrome - CONTINUATION	126
Turner syndrome - INITIATION	123
Turner syndrome - CONTINUATION	124
Adults and adolescents - INITIATION	127
Adults and adolescents - CONTINUATION	
Growth hormone deficiency in children - INITIATION	123
Growth hormone deficiency in children - CONTINUATION	123
Short stature due to chronic renal insufficiency - INITIATION	125
Short stature due to chronic renal insufficiency - CONTINUATION	
Short stature without growth hormone deficiency - INITIATION	
Short stature without growth hormone deficiency - CONTINUATION	124

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.	

PRES	CRI	BER PATIENT:
Name:		Name:
Ward		NHI:
Som	atro	ppin
Re-a	sses equi: C	PN – growth hormone deficiency in children sment required after 12 months sites (tick boxes where appropriate) Prescribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
and	or	 Growth hormone deficiency causing symptomatic hypoglycaemia, or with other significant growth hormone deficient sequelae (e.g. cardiomyopathy, hepatic dysfunction) and diagnosed with GH < 5 mcg/l on at least two random blood samples in the first 2 weeks of life, or from samples during established hypoglycaemia (whole blood glucose < 2 mmol/l using a laboratory device) Height velocity < 25th percentile for age; and adjusted for bone age/pubertal status if appropriate over 6 or 12 months using the standards of Tanner and Davies (1985) A current bone age is < 14 years (female patients) or < 16 years (male patients) Peak growth hormone value of < 5.0 mcg per litre in response to two different growth hormone stimulation tests. In children who are 5 years or older, GH testing with sex steroid priming is required If the patient has been treated for a malignancy, they should be disease free for at least one year based upon follow-up laboratory and radiological imaging appropriate for the malignancy, unless there are strong medical reasons why this is either not necessary or appropriate
		O Appropriate imaging of the pituitary gland has been obtained
Re-a	sses equi: C	JATION – growth hormone deficiency in children sment required after 12 months sites (tick boxes where appropriate) Prescribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
and	and and and	 Height velocity is greater than or equal to 25th percentile for age (adjusted for bone age/pubertal status if appropriate) while on growth hormone treatment, as calculated over six months using the standards of Tanner and Davis (1985) Height velocity is greater than or equal to 2.0 cm per year, as calculated over 6 months No serious adverse effect that the patients specialist considers is likely to be attributable to growth hormone treatment has occurred
Re-a	sses equi:	DN – Turner syndrome sment required after 12 months sites (tick boxes where appropriate)
Prescribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that ha endorsed by the Health NZ Hospital. and O The patient has a post-natal genotype confirming Turner Syndrome and		

O Height velocity is < 25th percentile over 6-12 months using the standards of Tanner and Davies (1985)

O A current bone age is < 14 years

I confirm that the above details are correct:

and

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.

ogist, or in accordance with a protocol or guideline that has been		
ogist, or in accordance with a protocol or guideline that has been		
growth bermana calculated over 6 to 12 menths using the		
growth hormone calculated over 6 to 12 months using the six months		
ogist, or in accordance with a protocol or guideline that has been for age or for bone age if there is marked growth acceleration al status if appropriate), as calculated over 6 to 12 months matients) or recognized severe skeletal dysplasia) and is not receiving		
CONTINUATION – short stature without growth hormone deficiency Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
ne age/pubertal status if appropriate) as calculated over 6 to er six months nder (male patients) o be attributable to growth hormone treatment has occurred		
r : : iik		

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.

PRES	CRIBER	R PATIENT:	
Name	:	Name:	
Ward:			
Som	atropin	in - continued	
INITI	ATION – s	- short stature due to chronic renal insufficiency	
		nent required after 12 months es (tick boxes where appropriate)	
(escribed by, or recommended by an endocrinologist, paediatric endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has	
and	and O The patient's height is more than 2 standard deviations below the mean and		
	and	Height velocity is < 25th percentile (adjusted for bone age/pubertal status if as standards of Tanner and Davies (1985)	opropriate) as calculated over 6 to 12 months using the
	and	${\sf O}$ A current bone age is to 14 years or under (female patients) or to 16 years or	under (male patients)
	O and	${\sf O}$ The patient is metabolically stable, has no evidence of metabolic bone diseas	e and absence of any other severe chronic disease
	O and	${\sf D}$ The patient is under the supervision of a specialist with expertise in renal med	licine
	O The patient has a GFR less than or equal to 30 ml/min/1.73 m ² as measured by the Schwartz method (Height(cm)/plasma creatinine (umol/l × 40 = corrected GFR (ml/min/1.73 m ²) in a child who may or may not be receiving dialysis		
		O The patient has received a renal transplant and has received < 5mg/ m ²	/day of prednisone or equivalent for at least 6 months
)
		TION – short stature due to chronic renal insufficiency nent required after 12 months	
		es (tick boxes where appropriate)	
(escribed by, or recommended by an endocrinologist, paediatric endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has	
and	0	 Height velocity is greater than or equal to 50th percentile (adjusted for bone a 12 months using the standards of Tanner and Davies (1985) 	ge/pubertal status if appropriate) as calculated over 6 to
	and O	 Height velocity is greater than or equal to 2 cm per year as calculated over six 	months
	and	${\sf O}$ A current bone age is 14 years or under (female patients) or 16 years or under	er (male patients)
	and O and	${\sf O}$ No serious adverse effect that the patients specialist considers is likely to be a	attributable to growth hormone has occurred
	and	O No malignancy has developed after growth hormone therapy was commenced	
	and) The patient has not experienced significant biochemical or metabolic deteriora	ation confirmed by diagnostic results
	and	${\sf D}$ The patient has not received renal transplantation since starting growth hormo	one treatment
	0	D If the patient requires transplantation, growth hormone prescription should cea be made after transplantation based on the above criteria	ase before transplantation and a new application should

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:	
Ward:	NHI:
Somatropin - continued	
INITIATION – Prader-Willi syndrome Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by an endocrinol endorsed by the Health NZ Hospital. and O The patient has a diagnosis of Prader-Willi and O The patient is aged six months or older and O A current bone age is < 14 years (female p and O Sleep studies or overnight oximetry have bor	been performed and there is no obstructive sleep disorder requiring treatment, or if an been adequately treated under the care of a paediatric respiratory physician and/or ENT
or O The patient is aged between six mon	diabetes or uncontrolled obesity defined by BMI that has increased by greater than or his in the preceding 12 months on the and two years and a thorough upper airway assessment is planned to be undertaken and at six to 12 weeks following treatment initiation
CONTINUATION – Prader-Willi syndrome Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by an endocrinol endorsed by the Health NZ Hospital.	plogist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been
12 months using the standards of Tanner a and Height velocity is greater than or equal to 2 and A current bone age is 14 years or under (fe and No serious adverse effect that the patient's and No malignancy has developed after growth and	2 cm per year as calculated over six months emale patients) or 16 years or under (male patients) s specialist con siders is likely to be attributable to growth hormone treatment has occurred in hormone therapy was commenced etes or uncontrolled obesity as defined by BMI that has increased by greater than or equal

Signed: D	Date:
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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:	
Somatropin - continued		
INITIATION – adults and adolescents Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)		
O Prescribed by, or recommended by an endocrinologist or paediatric endorsed by the Health NZ Hospital.	endocrinologist, or in accordance with a protocol or guideline that has been	
treatment of a pituitary tumour)	owth hormone deficiency (e.g. surgical removal of the pituitary for	
and The patient has undergone appropriate treatment of other hormonal deficiencies and psychological illnesses		
and O The patient has severe growth hormone deficiency (see notes)		
The patient's serum IGF-I is more than 1 standard deviation by	elow the mean for age and sex	
The patient has poor quality of life, as defined by a score of 16 growth hormone deficiency (QoL-AGHDA®)	or more using the disease-specific quality of life questionnaire for adult	
Note: For the purposes of adults and adolescents, severe growth hormone de equal to 3 mcg per litre during an adequately performed insulin tolerance test. Patients with one or more additional anterior pituitary hormone deficiencies ar isolated growth hormone deficiency require two growth hormone stimulation te an additional test is required, an arginine provocation test can be used with a	(ITT) or glucagon stimulation test. d a known structural pituitary lesion only require one test. Patients with ests, of which, one should be ITT unless otherwise contraindicated. Where	

The dose of somatropin should be started at 0.2 mg daily and be titrated by 0.1 mg monthly until it is within 1 standard deviation of the mean normal value for age and sex; and

The dose of somatropin not to exceed 0.7 mg per day for male patients, or 1 mg per day for female patients. At the commencement of treatment for hypopituitarism, patients must be monitored for any required adjustment in replacement doses of corticosteroid and levothyroxine.

I confirm that the above details are correc	t:
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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.

PRESC	RIBER		PATIENT:
Name:			Name:
Ward:			NHI:
Somat	tropin	- con	tinued
Re-ass	sessmer juisites) Prese	nt requ (tick b cribed	dults and adolescents ired after 12 months ioxes where appropriate) by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been y the Health NZ Hospital.
and			
		0	The patient has been treated with somatropin for < 12 months
	an	0	There has been an improvement in the Quality of Life Assessment defined as a reduction of at least 8 points on the Quality of Life Assessment of Growth Hormone Deficiency in Adults (QoL-AGHDA®) score from baseline
		Ο	Serum IGF-I levels have increased to within ±1SD of the mean of the normal range for age and sex
	an		The dose of somatropin does not exceed 0.7 mg per day for male patients, or 1 mg per day for female patients
c	or 🦳		
	score on treatment (other than due to obvious external factors such as external stressors)		The patient has been treated with somatropin for more than 12 months
			The patient has not had a deterioration in Quality of Life defined as a 6 point or greater increase from their lowest QoL-AGHDA® score on treatment (other than due to obvious external factors such as external stressors)
	an	0	Serum IGF-I levels have continued to be maintained within ±1SD of the mean of the normal range for age and sex (other than for obvious external factors)
	an		The dose of somatropin has not exceeded 0.7 mg per day for male patients or 1 mg per day for female patients
c	or	~	
and O The patient has undergone appropriate treatment of other hormonal deficiencies and psychological illnesses and O The patient has severe growth hormone deficiency (see notes)		The patient has had a Special Authority approval for somatropin for childhood deficiency in children and no longer meets the renewal criteria under this indication	
		The patient has undergone appropriate treatment of other hormonal deficiencies and psychological illnesses	
		The patient has severe growth hormone deficiency (see notes)	
	O The patient's serum IGF-I is more than 1 standard deviation below the mean for age and sex		The patient's serum IGF-I is more than 1 standard deviation below the mean for age and sex
	an		The patient has poor quality of life, as defined by a score of 16 or more using the disease-specific quality of life questionnaire for adult growth hormone deficiency (QoL-AGHDA®)
equal t	Note: For the purposes of adults and adolescents, severe growth hormone deficiency is defined as a peak serum growth hormone level of less than or equal to 3 mcg per litre during an adequately performed insulin tolerance test (ITT) or glucagon stimulation test. Patients with one or more additional anterior pituitary hormone deficiencies and a known structural pituitary lesion only require one test.		

Patients with one or more additional anterior pituitary hormone deficiencies and a known structural pituitary lesion only require one test. Patients with isolated growth hormone deficiency require two growth hormone stimulation tests, of which, one should be ITT unless otherwise contraindicated. Where an additional test is required, an arginine provocation test can be used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre. The dose of somatropin should be started at 0.2 mg daily and be titrated by 0.1 mg monthly until the serum IGF-I is within 1 standard deviation of the mean normal value for age and sex; and

The dose of somatropin not to exceed 0.7 mg per day for male patients, or 1 mg per day for female patients.

At the commencement of treatment for hypopituitarism, patients must be monitored for any required adjustment in replacement doses of corticosteroid and levothyroxine.

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:		
Liothyronine sodium - Tab 20 mcg			

Prerequisites (tick box where appropriate)

m O~ For a maximum of 14 days' treatment in patients with thyroid cancer who are due to receive radioiodine therapy

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:
Propylthiouracil	
INITIATION Prerequisites (tick boxes where appropriate)	
O The patient has hyperthyroidism	
The patient is intolerant of carbimazole or carbimazole is co	ntraindicated

Infections

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:	
Streptomycin sulphate		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:		
Amikacin			

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Tobramycin	

INITIATION

Prerequisites (tick box where appropriate)

()Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

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:
Tobramycin Solution for inhalation 60 mg per ml, 5 ml	
INITIATION Prerequisites (tick box where appropriate)	
O Patient has cystic fibrosis	

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:
Tobramcyin	
INITIATION Prerequisites (tick box where appropriate)	
O For addition to orthopaedic bone cement	

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:	
Paromomycin		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or gastroenterologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	
Imipenem with cilastatin		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Ertapenem	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	
Meropenem		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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.

PATIENT:		
Name:		
NHI:		

and			Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital		
		.	Ο	Proven infection with a carbapenem-resistant micro-organism, based on microbiology report	
		or	0	Probable infection with a carbapenem-resistant micro-organism, based on assessment by a clinical microbiologist or infectious disease specialist.	

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:
Ceftazadime	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Cefepime	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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.

PRES	CRIBER	PATIENT:
Name	:	Name:
Ward		NHI:
Cefta	aroline	
INITIATION – multi-resistant organisn salvage therapy Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and		
	O For patients where alternative therapies have failed	
	or \bigcirc For patients who have a contraindication or hypersensitivity to	standard current therapies

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:
Roxithromycin tab dispersible 50 mg	
INITIATION Prerequisites (tick box where appropriate)	
O Only for use in patients under 12 years of age	

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:
Clarithromycin	
INITIATION – Tab 250 mg and oral liquid Prerequisites (tick boxes where appropriate)	
O Atypical mycobacterial infection or O O Prophylaxis of infective endocarditis associated with surgical of	
INITIATION – Tab 500 mg Prerequisites (tick box where appropriate) O Helicobacter pylori eradication	
INITIATION – Infusion Prerequisites (tick boxes where appropriate)	

Atypical mycobacterial infection
or
O Atypical mycobacterial infection
or
O Mycobacterium tuberculosis infection where there is drug resistance or intolerance to standard pharmaceutical agents
or
O Community-acquired pneumonia

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:	
Azithromycin		
INITIATION – bronchiolitis obliterans syndrome, cystic fibrosis and atyp Prerequisites (tick boxes where appropriate)	ical Mycobacterium infections	
or O Patient has received a lung transplant and requires prophylaxi or O Patient has cystic fibrosis and has chronic infection with Pseur or O Patient has an atypical Mycobacterium infection	bone marrow transplant and requires treatment for bronchiolitis is for bronchiolitis obliterans syndrome* domonas aeruginosa or Pseudomonas related gram negative organisms*	
Note: Indications marked with * are unapproved indications		
INITIATION – non-cystic fibrosis bronchiectasis* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)		
O Prescribed by, or recommended by a respiratory specialist or paedia endorsed by the Health NZ Hospital.	atrician, or in accordance with a protocol or guideline that has been	
 For prophylaxis of exacerbations of non-cystic fibrosis bronchi and Patient is aged 18 and under and 	ectasis*	
or O Patient has had 3 or more exacerbations of their bronch O Patient has had 3 acute admissions to hospital for treatm	iectasis, within a 12 month period ment of infective respiratory exacerbations within a 12 month period	
Note: Indications marked with * are unapproved indications. A maximum of 24 months of azithromycin treatment for non-cystic fibrosis will be subsidised in the community.		
CONTINUATION – non-cystic fibrosis bronchiectasis* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a respiratory specialist or paedia endorsed by the Health NZ Hospital.	atrician, or in accordance with a protocol or guideline that has been	
and O The patient has completed 12 months of azithromycin treatme	ent for non-cystic fibrosis bronchiectasis	
And Following initial 12 months of treatment, the patient has not re bronchiectasis for a further 12 months, unless considered clin and	eceived any further azithromycin treatment for non-cystic fibrosis ically inappropriate to stop treatment	
O The patient will not receive more than a total of 24 months' az		
Note: Indications marked with * are unapproved indications. A maximum of 2 in the community.	4 months of azithromycin treatment for non-cystic fibrosis will be subsidised	
INITIATION – other indications Re-assessment required after 5 days Prerequisites (tick box where appropriate)		
O For any other condition		

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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Azithromycin - continued	
CONTINUATION – other indications Re-assessment required after 5 days Prerequisites (tick box where appropriate)	
O For any other condition	

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:	
Ticarcillin with clavulanic acid		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	
Piperacillin with tazobactam		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	
Ciprofloxacin		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:

Moxifloxacin

	ΙΑΤΙΟ	DN – Mycobacterium infection	
Prei	equis	sites (tick boxes where appropriate)	
and		Prescribed by, or recommended by an infectious disease specialist, clinical microbiologist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	
	Active tuberculosis		
		O Documented resistance to one or more first-line medications or	
		O Suspected resistance to one or more first-line medications (tuberculosis assumed to be contracted in an area with known resistance), as part of regimen containing other second-line agents or	
		O Impaired visual acuity (considered to preclude ethambutol use)	
		O Significant pre-existing liver disease or hepatotoxicity from tuberculosis medications or	
		O Significant documented intolerance and/or side effects following a reasonable trial of first-line medications	
	or or	 Mycobacterium avium-intracellulare complex not responding to other therapy or where such therapy is contraindicated Patient is under five years of age and has had close contact with a confirmed multi-drug resistant tuberculosis case 	
INITIATION – Pneumonia Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by an infectious disease specialist or clinical microbiologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Immunocompromised patient with pneumonia that is unresponsive to first-line treatment			
	or	O Pneumococcal pneumonia or other invasive pneumococcal disease highly resistant to other antibiotics	
		DN – Penetrating eye injury sites (tick box where appropriate)	
		Prescribed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	
and	0	Five days treatment for patients requiring prophylaxis following a penetrating eye injury	
		DN – Mycoplasma genitalium sites (tick boxes where appropriate)	
	and	O Has nucleic acid amplification test (NAAT) confirmed Mycoplasma genitalium and is symptomatic	
		O Has tried and failed to clear infection using azithromycin or	
		O Has laboratory confirmed azithromycin resistance	
	and	O Treatment is only for 7 days	

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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Tigecycline	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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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:
Daptomycin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Lincomycin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Linezolid	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Sulphadiazine	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or maternal-foetal medicine specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Teicoplanin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Fosfomycin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Pivmecillinam	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Vancomycin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Aztreonam, Chloramphenicol	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Clindamycin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Fusidic acid	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Colistin sulphomethate [Colestimethate]	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Ketoconazole - Tab 200 mg	

INITIATION

Prerequisites (tick box where appropriate)

()Prescribed by, or recommended by an oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

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:

Amphotericin B - Inj (liposomal) 50 mg vial

INITIATION

and

Prerequisites (tick boxes where appropriate)

C	Prescribed by, or recommended by a clinical microbiologist, haematologist, infectious disease specialist, oncologist, respiratory specialist or
	transplant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
and	

(\mathcal{O}	Proven or probable invasive fungal infection, to be prescribed under an established protocol	
or			

()Possible invasive fungal infection

() A multidisciplinary team (including an infectious disease physician or a clinical microbiologist) considers the treatment to be appropriate

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:	
Amphotericin B - Inj 50 mg vial		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, haematologist, infectious disease specialist, oncologist, respiratory specialist or transplant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	
Fluconazole		

INITIATION

Prerequisites (tick box where appropriate)

()Prescribed by, or recommended by a consultant, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

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:	
Itraconazole		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical immunologist, clinical microbiologist, dermatologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

Use this checklist to determine if a patient meets the restrictions for funding in the hospital setting	J. 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:
Vori	conazole	
	ATION – Proven or probable aspergillus infection	
Prer	equisites (tick boxes where appropriate)	
and	O Prescribed by, or recommended by a clinical microbiologist, haemat guideline that has been endorsed by the Health NZ Hospital.	tologist or infectious disease specialist, or in accordance with a protocol or
	O Patient is immunocompromised and	
	O Patient has proven or probable invasive aspergillus infection	
	ATION – Possible aspergillus infection equisites (tick boxes where appropriate)	
and	O Prescribed by, or recommended by a clinical microbiologist, haemat guideline that has been endorsed by the Health NZ Hospital.	tologist or infectious disease specialist, or in accordance with a protocol or
	O Patient is immunocompromised	
	And O Patient has possible invasive aspergillus infection	
	A multidisciplinary team (including an infectious disease phys	ician) considers the treatment to be appropriate
	ATION – Resistant candidiasis infections and other moulds equisites (tick boxes where appropriate)	
and	O Prescribed by, or recommended by a clinical microbiologist, haemat guideline that has been endorsed by the Health NZ Hospital.	ologist or infectious disease specialist, or in accordance with a protocol or
ana	O Patient is immunocompromised	
	O Patient has fluconazole resistant candidiasis	
	or O Patient has mould strain such as Fusarium spp. and So	cedosporium spp
	and A multidisciplinary team (including an infectious disease phys	ician or clinical microbiologist) considers the treatment to be appropriate
INITIATION – Invasive fungal infection prophylaxis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)		
O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the He NZ Hospital.		
	O The patient is at risk of invasive fungal infection and	
		ematologist, transplant physician, infectious disease specialist,
	O Prescribing voriconazole is in accordance with a protoco	ol or guideline that has been endorsed by the Health New Zealand - Te is a greater than 10% risk of invasive fungal infection (IFI)

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.

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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:		

Posaconazole

INITIATION Re-assessment required after 6 weeks			
Prerequisites (tick boxes where appropriate)			
O Prescribed by, or recommended by a haematologist or infectious disease specialist, or in accordance with a protocol or guideline that has be endorsed by the Health NZ Hospital.			
O Patient has acute myeloid leukaemia or			
O Patient is planned to receive a stem cell transplant and is at high risk for aspergillus infection			
And O Patient is to be treated with high dose remission induction therapy or re-induction therapy			
CONTINUATION Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate)			
O Prescribed by, or recommended by a haematologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
O Patient has previously received posaconazole prophylaxis during remission induction therapy and			
O Patient is to be treated with high dose remission re-induction therapy			
O Patient is to be treated with high dose consolidation therapy			
or O Patient is receiving a high risk stem cell transplant			
INITIATION – Invasive fungal infection prophylaxis Re-assessment required after 6 months			
Prerequisites (tick boxes where appropriate)			
O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
O The patient is at risk of invasive fungal infection			
O Posaconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease specialist, paediatric haematologist or paediatric oncologist			
Prescribing posaconazole is in accordance with a protocol or guideline that has been endorsed by the Health New Zealand - Te Whatu Ora Hospital in the specific settings where there is a greater than 10% risk of invasive fungal infection (IFI)			

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:
Posa	icon	azo	le - a	continued	
CONTINUATION – Invasive fungal infection prophylaxis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline to NZ Hospital. and		cordance with a protocol or guideline that has been endorsed by the Health			
	and	O The patient is at risk of invasive fungal infection			
		or	0	Posaconazole is prescribed by, or recommended by a hap paediatric haematologist or paediatric oncologist	aematologist, transplant physician, infectious disease specialist,
			Ο		ol or guideline that has been endorsed by the Health New Zealand - Te s a greater than 10% risk of invasive fungal infection (IFI)

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:	
Flucytosine		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	
Caspofungin		

Prerequisites (tick boxes where appropriate)					
and	0	Prescribed by, or recommended by a clinical microbiologist, haematologist, infectious disease specialist, oncologist, respiratory specialist or transplant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
	or	O Proven or probable invasive fungal infection, to be prescribed under an established protocol or			
		and Possib	le invasive fungal infection		
		\cap	idisciplinary team (including an infectious disease physician or a clinical microbiologist) considers the treatment to be priate		

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:	
Clofazimine		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, dermatologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	
Dapsone		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, dermatologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	
Cycloserine		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	
Isoniazid with rifampicin		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, dermatologist, paediatrician, public health physician or internal medicine physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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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:
Pyrazinamide	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Rifampicin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, dermatologist, internal medicine physician, paediatrician or public health physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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

RIBER		PATIENT:
		Name:
		NHI:
quiline		
sessmen	nulti-drug resistant tuberculosis t required after 6 months (tick boxes where appropriate)	
0	The person has multi-drug resistant tuberculosis (MDR-TB)	
O	Ministry of Health's Tuberculosis Clinical Network has reviewe treatment regimen	ed the individual case and recommends bedaquiline as part of the

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:
Isoniazid	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, dermatologist, paediatrician, public health physician or internal medicine physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Rifabutin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, gastroenterologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Ethambutol hydrochloride	

INITIATION

Prerequisites (tick box where appropriate)

()Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

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:
Para-aminosalicylic Acid	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Protionamide	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Albendazole	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Ivermectin	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, dermatologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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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:
Artemether with lumefantrine	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Artesunate	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	
Atovaquone with proguanil hydrochloride		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Chloroquine phosphate	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, dermatologist, infectious disease specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Mefloquine hydrochloride	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, dermatologist, infectious disease specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Pentamidine isethionate	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Primaguine phosphate	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Pyrimethamine	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or maternal-foetal medicine specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Quinine dihvdrochloride	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Sodium stibogluconate	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	
Spiramycin		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a maternal-foetal medicine specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Nitazoxanide	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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.

PRESCRIBE	R		PATIENT:
Name:			Name:
Vard:			NHI:
Ion-Nucle	oside	e Reverse Transcriptase Inhibitors	
INITIATION Prerequisite		rmed HIV box where appropriate)	
О Ра	tient ha	s confirmed HIV infection	
		ention of maternal transmission boxes where appropriate)	
or		vention of maternal foetal transmission trment of the newborn for up to eight weeks	
Prerequisite	es (tick	exposure prophylaxis following exposure to HIV boxes where appropriate) trment course to be initiated within 72 hours post exposu	e
	and Patient has had condomless anal intercourse or receptive vaginal intercourse with a known HIV positive person with an unknown or detectable viral load greater than 200 copies per mI or O Patient has shared intravenous injecting equipment with a known HIV positive person or O Patient has had non-consensual intercourse and the clinician considers that the risk assessment indicates prophylaxis is required		s per ml
	Ő (Patient has had condomless anal intercourse with a per is unknown	son from a high HIV prevalence country or risk group whose HIV status
Note: Refer	to local	health pathways or the Australasian Society for HIV, Vira	Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.ash
Prerequisite	es (tick	utaneous exposure box where appropriate) s percutaneous exposure to blood known to be HIV positi	ve

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	RIBE	R		PATIENT:
Name:				Name:
Ward:				NHI:
Nucle	osid	e Re	verse Transcriptase Inhibitors	
			firmed HIV k box where appropriate)	
C) Pa	tient h	as confirmed HIV infection	
	INITIATION – Prevention of maternal transmission Prerequisites (tick boxes where appropriate)			
	or		evention of maternal foetal transmission eatment of the newborn for up to eight weeks	
Prerec	INITIATION – Post-exposure prophylaxis following exposure to HIV Prerequisites (tick boxes where appropriate)			
	and Patient has had condomless anal intercourse or receptive vaginal intercourse with a known HIV positive person with an unknown or detectable viral load greater than 200 copies per ml			
		C	Patient has shared intravenous injecting equipment wi	th a known HIV positive person
	or O Patient has had non-consensual intercourse and the clinician considers that the risk assessment indicates prophylaxis is required		linician considers that the risk assessment indicates prophylaxis is	
		or C	Patient has had condomless anal intercourse with a period is unknown	erson from a high HIV prevalence country or risk group whose HIV status
Note:	Note: Refer to local health pathways or the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.ashr			
	quisite	es (ticl	cutaneous exposure k box where appropriate) has percutaneous exposure to blood known to be HIV posi	tive

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.

PRESCRI	BER			PATIENT:
Name:				Name:
Ward:				NHI:
Proteas	e Inł	nibite	ors	
			med HIV oox where appropriate)	
0	Patie	nt has	confirmed HIV infection	
			ntion of maternal transmission	
or	0 0		ention of maternal foetal transmission ment of the newborn for up to eight weeks	
			exposure prophylaxis following exposure to HIV boxes where appropriate)	
and	d	Treat	ment course to be initiated within 72 hours post exposu	e
	or	0	Patient has had condomless anal intercourse or recepti unknown or detectable viral load greater than 200 copie	ve vaginal intercourse with a known HIV positive person with an s per ml
	-	Ο	Patient has shared intravenous injecting equipment with	a known HIV positive person
	or	0	Patient has had non-consensual intercourse and the clin required	nician considers that the risk assessment indicates prophylaxis is
	or	0	Patient has had condomless anal intercourse with a per is unknown	son from a high HIV prevalence country or risk group whose HIV status
Note: Re	efer to	local	health pathways or the Australasian Society for HIV, Vira	Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.ash
	sites	(tick k	taneous exposure pox where appropriate) percutaneous exposure to blood known to be HIV positi	ve

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.

RESCRIBER		PATIENT:
ame:		Name:
ard:		NHI:
rand Tran	sfer Inhibitors	
	Confirmed HIV (tick box where appropriate)	
O Patie	nt has confirmed HIV infection	
	Prevention of maternal transmission (tick boxes where appropriate)	
or O	Prevention of maternal foetal transmission Treatment of the newborn for up to eight weeks	
	Post-exposure prophylaxis following exposure to HIV (tick boxes where appropriate) Treatment course to be initiated within 72 hours post exposu	Ire
or	 Patient has had condomless anal intercourse or recept unknown or detectable viral load greater than 200 copi Patient has shared intravenous injecting equipment wit 	
or		inician considers that the risk assessment indicates prophylaxis is
	O Patient has had condomless anal intercourse with a period is unknown	rson from a high HIV prevalence country or risk group whose HIV status
ote: Refer to	local health pathways or the Australasian Society for HIV, Vira	al Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.a
rerequisites	Percutaneous exposure (tick box where appropriate) ent has percutaneous exposure to blood known to be HIV posit	ive

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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:

Ledipasvir with sofosbuvir

Note: Only for use in patients with approval by the Hepatitis C Treatment Panel (HepCTP). Applications will be considered by HepCTP at its regular meetings and approved subject to eligibility according to the Access Criteria (set out in Section B of the Pharmaceutical Schedule).

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:
Cidofovir	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist, otolaryngologist or oral surgeon, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:	
Foscarnet sodium		

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

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:
Ganciclovir	

INITIATION

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()

PRESCR	RIBER	PATIENT:
	ciclovir	
INITIATI Re-asse	ION – Transplant cytomegalovirus prophylaxis essment required after 3 months uisites (tick box where appropriate) Patient has undergone a solid organ transplant and requires va	Ilganciclovir for CMV prophylaxis
Re-asse	UUATION – Transplant cytomegalovirus prophylaxis essment required after 3 months uisites (tick boxes where appropriate)	
or	CMV prophylaxis and O Patient is to receive a maximum of 90 days of valge	d received anti-thymocyte globulin and requires valganciclovir therapy for anciclovir prophylaxis following anti-thymocyte globulin
	O Patient has received pulse methylprednisolone for prophylaxis and	acute rejection and requires further valganciclovir therapy for CMV anciclovir prophylaxis following pulse methylprednisolone
-		
Re-asse	ION – Lung transplant cytomegalovirus prophylaxis essment required after 12 months isites (tick boxes where appropriate) Prescribed by, or recommended by a relevant specialist, or in a	accordance with a protocol or guideline that has been endorsed by the Health NZ
Re-asse	essment required after 12 months lisites (tick boxes where appropriate) Prescribed by, or recommended by a relevant specialist, or in a Hospital.	accordance with a protocol or guideline that has been endorsed by the Health NZ
Re-asse Prerequ	essment required after 12 months uisites (tick boxes where appropriate) Prescribed by, or recommended by a relevant specialist, or in a Hospital. O Patient has undergone a lung transplant or O The donor was cytomegalovirus positive and the part or O The recipient is cytomegalovirus positive	
Re-asse Prerequ and and an INITIATI	essment required after 12 months uisites (tick boxes where appropriate) Prescribed by, or recommended by a relevant specialist, or in a Hospital. O Patient has undergone a lung transplant O The donor was cytomegalovirus positive and the part or O The recipient is cytomegalovirus positive Ind	

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:
Emtricitabine with tenofovir disoproxil	
INITIATION – Confirmed HIV	
Prerequisites (tick box where appropriate)	
O Patient has confirmed HIV infection	
INITIATION – Prevention of maternal transmission Prerequisites (tick boxes where appropriate)	
O Prevention of maternal foetal transmission	
O Treatment of the newborn for up to eight weeks	
INITIATION – Post-exposure prophylaxis following non-occupational exp	posure to HIV
Prerequisites (tick boxes where appropriate)	
O Treatment course to be initiated within 72 hours post exposure	
O Patient has had unprotected receptive anal intercourse	with a known HIV positive person
O Patient has shared intravenous injecting equipment with	a known HIV positive person
O Patient has had non-consensual intercourse and the clin required	nician considers that the risk assessment indicates prophylaxis is
INITIATION – Percutaneous exposure Prerequisites (tick box where appropriate) O Patient has percutaneous exposure to blood known to be HIV positive	/e
INITIATION – Pre-exposure prophylaxis Re-assessment required after 24 months Prerequisites (tick boxes where appropriate)	
O Patient has tested HIV negative, does not have signs or symp	toms of acute HIV infection and has been assessed for HIV seroconversion
O The Practitioner considers the patient is at elevated risk of HIV	/ exposure and use of PrEP is clinically appropriate
Note: Refer to local health pathways or the Australasian Society for HIV, Viral	Hepatitis and Sexual Health Medicine clinical guidelines (https://ashm.org.au/HIV/F
CONTINUATION – Pre-exposure prophylaxis Re-assessment required after 24 months Prerequisites (tick boxes where appropriate)	
	toms of acute HIV infection and has been assessed for HIV seroconversion
The Practitioner considers the patient is at elevated risk of HIV	/ exposure and use of PrEP is clinically appropriate
Note: Refer to local health pathways or the Australasian Society for HIV, Viral	Hepatitis and Sexual Health Medicine clinical guidelines (https://ashm.org.au/HIV/F

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		IBER	PATIENT:
Name	:		Name:
Ward:			NHI:
Osel	tan	nivir	
INITI. Prere		ON isites (tick boxes where appropriate)	
		O Only for hospitalised patient with known or suspected influenza	a
	or O For prophylaxis of influenza in hospitalised patients as part of a Health NZ Hospital approved infections control plan		

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:
Zana	ami	ivir - Powder for inhalation 5 mg	
INITI Prer		ON iisites (tick boxes where appropriate)	
O Only for hospitalised patient with known or suspected influenza or O For prophylaxis of influenza in hospitalised patients as part of a Health NZ Hospital approved infections control plan		O Only for hospitalised patient with known or suspected influenz	a
		a Health NZ Hospital approved infections control plan	

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:		
COVID-19 treatments			

INITIATION

Prerequisites (tick box where appropriate)

Only if patient meets access criteria (as per https://pharmac.govt.nz/covid-oral-antivirals). Note the supply of treatment is via Pharmac's approved distribution process. Refer to the Pharmac website for more information about this and stock availability ()

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:
Remdesivir	

INITIATION – Treatment of mild to moderate COVID-19

Prerequisites (tick box where appropriate)

 \bigcirc Only if patient meets access criteria (as per https://pharmac.govt.nz/covid-oral-antivirals). Note the supply of treatment is via Pharmac's approved distribution process. Refer to the Pharmac website for more information about this and stock availability

Re-as	ssessme	COVID-19 in hospitalised patients nt required after 5 doses
Prere	equisites	(tick boxes where appropriate)
	and	Patient is hospitalised with confirmed (or probable) symptomatic COVID-19
		Patient is considered to be at high risk of progression to severe disease
	O	Patient's symptoms started within the last 7 days
	and	Patient does not require, or is not expected to require, mechanical ventilation
	and	Not to be used in conjunction with other funded COVID-19 antiviral treatments
	and	Treatment not to exceed five days

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:
Interferon gamma	
INITIATION Prerequisites (tick box where appropriate)	
m O Patient has chronic granulomatous disease and requires interferon g	gamma

RS1827 - Pegylated interferon alfa-2a

Chronic Hepatitis C - genotype 1 infection treatment more than 4 years prior - INITIATION Chronic hepatitis C - genotype 1 infection - CONTINUATION	
Chronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV or genotype 2 or 3 post liver tra - INITIATION	
Chronic hepatitis C - genotype 2 or 3 infection without co-infection with HIV - INITIATION Hepatitis B - INITIATION	
Myeloproliferative disorder or cutaneous T cell lymphoma - INITIATION Myeloproliferative disorder or cutaneous T cell lymphoma - CONTINUATION	
Ocular surface squamous neoplasia - INITIATIÓN Ocular surface squamous neoplasia - CONTINUATION	
Post-allogenic bone marrow transplant - INITIATION Post-allogenic bone marrow transplant - CONTINUATION	221

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:

Pegylated interferon alfa-2a

INITIATION – Chronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV or genotype 2 or 3 post liver transplant Re-assessment required after 48 weeks
Prerequisites (tick boxes where appropriate)
O Patient has chronic hepatitis C, genotype 1, 4, 5 or 6 infection or O Patient has chronic hepatitis C and is co-infected with HIV
O Patient has chronic hepatitis C genotype 2 or 3 and has received a liver transplant
Note: Consider stopping treatment if there is absence of a virological response (defined as at least a 2-log reduction in viral load) following 12 weeks of treatment since this is predictive of treatment failure. Consider reducing treatment to 24 weeks if serum HCV RNA level at Week 4 is undetectable by sensitive PCR assay (less than 50IU/ml) AND Baseline serum HCV RNA is less than 400,000IU/ml.
CONTINUATION – Chronic hepatitis C - genotype 1 infection Re-assessment required after 48 weeks Prerequisites (tick boxes where appropriate)
O Prescribed by, or recommended by a gastroenterologist, infectious disease specialist or general physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
O Patient has chronic hepatitis C, genotype 1 and
O Patient has had previous treatment with pegylated interferon and ribavirin and
O Patient has responder relapsed
or O Patient was a partial responder
Patient is to be treated in combination with boceprevir
INITIATION – Chronic Hepatitis C - genotype 1 infection treatment more than 4 years prior Re-assessment required after 48 weeks Prerequisites (tick boxes where appropriate)
O Prescribed by, or recommended by a gastroenterologist, infectious disease specialist or general physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
O Patient has chronic hepatitis C, genotype 1 and
O Patient has had previous treatment with pegylated interferon and ribavirin and
O Patient has responder relapsed
or O Patient was a partial responder
O Patient received interferon treatment prior to 2004
And O Patient is to be treated in combination with boceprevir

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:
Pegylated interferon alfa-2a - continued	
INITIATION – Chronic hepatitis C - genotype 2 or 3 infection without co-i Re-assessment required after 6 months Prerequisites (tick box where appropriate) O Patient has chronic hepatitis C, genotype 2 or 3 infection	nfection with HIV
INITIATION – Hepatitis B Re-assessment required after 48 weeks Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a gastroenterologist, infectious of guideline that has been endorsed by the Health NZ Hospital.	lisease specialist or general physician, or in accordance with a protocol or
 Patient has confirmed Hepatitis B infection (HBsAg positive fo and Patient is Hepatitis B treatment-naive ALT > 2 times Upper Limit of Normal 	r more than 6 months)
and HBV DNA < 10 log10 IU/ml and	
O HBeAg positive or O Serum HBV DNA greater than or equal to 2,000 units/m moderate fibrosis)	I and significant fibrosis (greater than or equal to Metavir Stage F2 or
and Compensated liver disease and	
No continuing alcohol abuse or intravenous drug use and Not co-infected with HCV, HIV or HDV and	
O Neither ALT nor AST > 10 times upper limit of normal and O No history of hypersensitivity or contraindications to pegylated	l interferon
INITIATION – myeloproliferative disorder or cutaneous T cell lymphoma Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
or O Patient has a cutaneous T cell lymphoma*	
and O Patient is intolerant of hydroxyurea and O Treatment with anagrelide and busulfan is not clinically a	appropriate
or O Patient has a myeloproliferative disorder	
O Patient is pregnant, planning pregnancy or lactating	

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.

Name:		PATIENT:
		Name:
Ward:		NHI:
Pegylated in	terferon alfa-2a - continued	
CONTINUATIO Re-assessment	N – myeloproliferative disorder or cutaneous T cell ly t required after 12 months (tick boxes where appropriate)	mphoma
and	No evidence of disease progression The treatment remains appropriate and patient is benefit O Patient has a cutaneous T cell lymphoma* and O Patient has a myeloproliferative disorder* and O Remains intolerant of hydroxyurea and O Patient is pregnant, planning pregnand	treatment with anagrelide and busulfan remains clinically inappropriate
Note: Indication	ns marked with * are unapproved indications	
O Presc Hospi		ccordance with a protocol or guideline that has been endorsed by the Health NZ
and O Patier	nt has ocular surface squamous neoplasia*	
O Patier CONTINUATIO Re-assessment	nt has ocular surface squamous neoplasia* N – ocular surface squamous neoplasia t required after 12 months (tick box where appropriate)	
O Patier CONTINUATIO Re-assessment Prerequisites (N – ocular surface squamous neoplasia t required after 12 months (tick box where appropriate) ribed by, or recommended by an ophthalmologist, or in a	cordance with a protocol or guideline that has been endorsed by the Health NZ
O Patier CONTINUATIO Re-assessment Prerequisites (O Presc Hospi and O The tr	N – ocular surface squamous neoplasia t required after 12 months (tick box where appropriate) ribed by, or recommended by an ophthalmologist, or in a	
Patier CONTINUATIO Re-assessment Prerequisites (Presc Hospi and The tr Note: Indication INITIATION – p Re-assessment Prerequisites (N – ocular surface squamous neoplasia t required after 12 months (tick box where appropriate) pribed by, or recommended by an ophthalmologist, or in a tital.	om treatment
O Patier CONTINUATIO Re-assessment Prerequisites (O Presc Hospi and O The tr Note: Indication INITIATION – p Re-assessment Prerequisites (O Patier CONTINUATIO Re-assessment	N – ocular surface squamous neoplasia t required after 12 months (tick box where appropriate) tribed by, or recommended by an ophthalmologist, or in ad ital. reatment remains appropriate and patient is benefitting from ms marked with * are unapproved indications post-allogenic bone marrow transplant t required after 3 months (tick box where appropriate)	om treatment

Signed: Date:

Musculoskeletal System

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:
Edrophonium chloride	
INITIATION Prerequisites (tick box where appropriate)	
${ m O}~$ For the diagnosis of myasthenia gravis	

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:

Denosumab

(and	С	The	patient has established osteoporosis
		0	History of one significant osteoporotic fracture demonstrated radiologically, with a documented T-Score less than or equal to -2.5, that incorporates BMD measured using dual-energy x-ray absorptiometry (DEXA)
	or	0	History of one significant osteoporotic fracture, demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of logistical, technical or pathophysiological reasons
	or	0	History of two significant osteoporotic fractures demonstrated radiologically
	or	Ο	Documented T-Score less than or equal to -3.0
	or	0	A 10-year risk of hip fracture greater than or equal to 3%, calculated using a published risk assessment algorithm that incorporates BMD measured using DEXA
and			
	or	Ο	Bisphosphonates are contraindicated because the patient's creatinine clearance or eGFR is less than 35 mL/min
		Ο	The patient has experienced at least two symptomatic new fractures or a BMD loss greater than 2% per year, after at least 12 months' continuous therapy with a funded antiresorptive agent
	or	0	Bisphosphonates result in intolerable side effects
	or	\bigcirc	Intravenous bisphosphonates cannot be administered due to logistical or technical reasons

INITIATION – Hypercalcaemia

Prerequisites (tick boxes where appropriate)



Patient has hypercalcaemia of malignancy

Patient has severe renal impairment

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:

Raloxifene

ATI(equi		(tick boxes where appropriate)
or	0	History of one significant osteoporotic fracture demonstrated radiologically and documented bone mineral density (BMD) greater than or equal to 2.5 standard deviations below the mean normal value in young adults (i.e. T-Score less than or equal to -2.5) (see Notes)
	0	History of one significant osteoporotic fracture demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of major logistical, technical or pathophysiological reasons. It is unlikely that this provision would apply to many patients under 75 years of age
or or	Ο	History of two significant osteoporotic fractures demonstrated radiologically
or	Ο	Documented T-Score greater than or equal to -3.0 (see Notes)
	0	A 10-year risk of hip fracture greater than or equal to 3%, calculated using a published risk assessment algorithm (e.g. FRAX or Garvan) which incorporates BMD measurements (see Notes)
or	0	Patient has had a Special Authority approval for zoledronic acid (Underlying cause - Osteoporosis) or has had a Special Authority approval for alendronate (Underlying cause - Osteoporosis) prior to 1 February 2019

Note:

- a) BMD (including BMD used to derive T-Score) must be measured using dual-energy x-ray absorptiometry (DXA). Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable.
- b) Evidence suggests that patients aged 75 years and over who have a history of significant osteoporotic fracture demonstrated radiologically are very likely to have a T-Score less than or equal to -2.5 and, therefore, do not require BMD measurement for raloxifene funding.
- c) Osteoporotic fractures are the incident events for severe (established) osteoporosis, and can be defined using the WHO definitions of osteoporosis and fragility fracture. The WHO defines severe (established) osteoporosis as a T-score below -2.5 with one or more associated fragility fractures. Fragility fractures are fractures that occur as a result of mechanical forces that would not ordinarily cause fracture (minimal trauma). The WHO has quantified this as forces equivalent to a fall from a standing height or less.
- d) A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

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	CRIBER	PATIENT:	
Name:		Name:	
Ward:		NHI:	

Teriparatide

Re-a		t required after 18 months
Prer	equisites	(tick boxes where appropriate)
	and	The patient has severe, established osteoporosis
	and	The patient has a documented T-score less than or equal to -3.0 (see Notes)
	and	The patient has had two or more fractures due to minimal trauma
	0	The patient has experienced at least one symptomatic new fracture after at least 12 months' continuous therapy with a funded antiresorptive agent at adequate doses (see Notes)

Note:

 a) The bone mineral density (BMD) measurement used to derive the T-score must be made using dual-energy x-ray absorptiometry (DXA). Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable

- b) Antiresorptive agents and their adequate doses for the purposes of this restriction are defined as: alendronate sodium tab 70 mg or tab 70 mg with colecalciferol 5,600 iu once weekly; raloxifene hydrochloride tab 60 mg once daily; zoledronic acid 5 mg per year. If an intolerance of a severity necessitating permanent treatment withdrawal develops during the use of one antiresorptive agent, an alternate antiresorptive agent must be trialled so that the patient achieves the minimum requirement of 12 months' continuous therapy.
- c) A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

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.

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Rasburicase			

INITIATION

Prerequisites (tick box where appropriate)

()Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

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:

Febuxostat

(О	Patie	ant has been diagnosed with gout
and	_		
		0	The patient has a serum urate level greater than 0.36 mmol/l despite treatment with allopurinol at doses of at least 600 mg/day and addition of probenecid at doses of up to 2 g per day or maximum tolerated dose
	or	Ο	The patient has experienced intolerable side effects from allopurinol such that treatment discontinuation is required and serum urate remains greater than 0.36 mmol/l despite use of probenecid at doses of up to 2 g per day or maximum tolerated dose
	or	0	The patient has renal impairment such that probenecid is contraindicated or likely to be ineffective and serum urate remains greater than 0.36 mmol/l despite optimal treatment with allopurinol (see Note)
	or	0	The patient has previously had an initial Special Authority approval for benzbromarone for treatment of gout.

INITIATION – Tumour lysis syndrome Re-assessment required after 6 weeks

Prerequisites (tick boxes where appropriate)

O Prescribed by, or recommended by a haematologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

O Patient is scheduled to receive cancer therapy carrying an intermediate or high risk of tumour lysis syndrome and

O Patient has a documented history of allopurinol intolerance

CONTINUATION – Tumour lysis syndrome

Re-assessment required after 6 weeks **Prerequisites** (tick box where appropriate)

()

and

Prescribed by, or recommended by a haematologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

The treatment remains appropriate and patient is benefitting from treatment

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:	

Sugammadex

INITI. Prere			(tick boxes where appropriate)
	or	0	Patient requires reversal of profound neuromuscular blockade following rapid sequence induction that has been undertaken using rocuronium (i.e. suxamethonium is contraindicated or undesirable)
	or	Ο	Severe neuromuscular degenerative disease where the use of neuromuscular blockade is required
		Ο	Patient has an unexpectedly difficult airway that cannot be intubated and requires a rapid reversal of anaesthesia and neuromuscular blockade
	or or	Ο	The duration of the patient's surgery is unexpectedly short
	or	0	Neostigmine or a neostigmine/anticholinergic combination is contraindicated (for example the patient has ischaemic heart disease, morbid obesity or COPD)
		0	Patient has a partial residual block after conventional reversal

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:
Etoricoxib	
INITIATION Prerequisites (tick box where appropriate)	
${ m O}~$ For in-vivo investigation of allergy only	

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:
Capsaicin	

Prerequisites (tick box where appropriate)

O Patient has osteoarthritis that is not responsive to paracetamol and oral non-steroidal anti-inflammatories are contraindicated

Nervous System

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:
Riluzole	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a neurologist or respiratory spectory by the Health NZ Hospital.	ialist, or in accordance with a protocol or guideline that has been endorsed
 The patient has amyotrophic lateral sclerosis with disease dura and The patient has at least 60 percent of predicted forced vital cal and The patient has not undergone a tracheostomy and The patient has not experienced respiratory failure 	
O The patient is ambulatory	

O The patient is able to use upper limbs or

 \bigcirc The patient is able to swallow

CONTINUATION

or

Re-assessment required after 18 months

Prerequisites (tick boxes where appropriate)

and		The p	patient has not undergone a tracheostomy
and (С	The p	patient has not experienced respiratory failure
		Ο	The patient is ambulatory
	or	Ο	The patient is able to use upper limbs
	or	Ο	The patient is able to swallow

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.

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Sucrose			
INITIATION Prerequisites (tick box where appropriate)			
O For use in neonatal patients only			

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.

PRES	CRIBER		PATIENT:
Name	:		Name:
Ward:			NHI:
Meth	oxyflur	ane	
	ATION equisites	(tick boxes where appropriate)	
	and	Patient is undergoing a painful procedure with an expected du	ration of less than one hour
	O	Only to be used under supervision by a medical practitioner or	r nurse who is trained in the use of methoxyflurane

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:
Paracetamol	

INITIATION

Prerequisites (tick box where appropriate)

()Intravenous paracetamol is only to be used where other routes are unavailable or impractical, or where there is reduced absorption. The need for IV paracetamol must be re-assessed every 24 hours

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:
Capsaicin	
INITIATION Prerequisites (tick box where appropriate)	
${ m O}~$ For post-herpetic neuralgia or diabetic peripheral neuropathy	

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:	

Vigabatrin

Re-a		men	required after 15 months ick boxes where appropriate)	
	O Patient has infantile spasms			
O Patient has epilepsy		O Patient has epilepsy and		
			O Seizures are not adequately controlled with optimal treatment with other antiepilepsy agents	
			O Seizures are controlled adequately but the patient has experienced unacceptable side effects from optimal treatment with other antiepilepsy agents	
		or	O Patient has tuberous sclerosis complex	
	and			
	Patient is, or will be, receiving regular automated visual field testing (ideally before starting therapy and on a 6-monthly basis thereafter)			
	or O It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields			
\subseteq				
	ITINU. equis		I ick boxes where appropriate)	
	·			
	and	\bigcirc	The patient has demonstrated a significant and sustained improvement in seizure rate or severity and or quality of life	
		or	O Patient is receiving regular automated visual field testing (ideally every 6 months) on an ongoing basis for duration of treatment with vigabatrin	

O It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields

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:
Lacosamide	
INITIATION Re-assessment required after 15 months Prerequisites (tick boxes where appropriate)	
Patient has focal epilepsy	
And Seizures are not adequately controlled by, or patient has experienced unacceptable side effects from, optimal treatment following: sodium valproate, topiramate, levetiracetam, and any two of carbamazepine, lamotrigine, and phenytoin sodium Note: These of childbearing potential are not required to trial phenytoin sodium sodium valproate, or topiramate. These who can father	

Note: Those of childbearing potential are not required to trial phenytoin sodium, sodium valproate, or topiramate. Those who can father children are not required to trial sodium valproate.

CONTINUATION

Prerequisites (tick box where appropriate)

() Patient has demonstrated a significant and sustained improvement in seizure rate or severity and/or quality of life compared with that prior to starting lacosamide treatment

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:	

Stiripentol

and

()

INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a paediatric neurologist, or in accordance with a protocol or guideline that has been endorsed by the NZ Hospital.	Health
 Patient has confirmed diagnosis of Dravet syndrome Seizures have been inadequately controlled by appropriate courses of sodium valproate, clobazam and at least two of the followin topiramate, levetiracetam, ketogenic diet 	g:
Note: Those of childbearing potential are not required to trial sodium valproate or topiramate. Those who can father children are not required to trial sodium valproate.	ial
CONTINUATION Prerequisites (tick box where appropriate)	

O Prescribed by, or recommended by a paediatric neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

Patient continues to benefit from treatment as measured by reduced seizure frequency from baseline

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:	
Hyoscine hydrobromide - Patch 1.5 mg		

	Prer			(tick boxes where appropriate)
			0	Control of intractable nausea, vomiting, or inability to swallow saliva in the treatment of malignancy or chronic disease where the patient cannot tolerate or does not adequately respond to oral anti-nausea agents
		or	Ο	Control of clozapine-induced hypersalivation where trials of at least two other alternative treatments have proven ineffective
	or C	0	For treatment of post-operative nausea and vomiting where cyclizine, droperidol and a 5HT3 antagonist have proven ineffective, are not tolerated or are contraindicated	

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:	
Aprepitant		

Prerequisites (tick box where appropriate)

O Patient is undergoing highly emetogenic chemotherapy and/or anthracycline-based chemotherapy for the treatment of malignancy

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:

Paliperidone

sses	smer		uired after 12 months poxes where appropriate)
or	0		patient has had an initial Special Authority approval for risperidone depot injection or olanzapine depot injection or aripiprazole of injection
	an an	Ο	The patient has schizophrenia or other psychotic disorder The patient has been unable to adhere to treatment using oral atypical antipsychotic agents The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in the last 12 months

CONTINUATION

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

The initiation of paliperidone depot injection has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of an atypical antipsychotic depot injection \bigcirc

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:
Paliperidone palmitate	
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O The patient has schizophrenia and O The patient has had an initial Special Authority approval for patient for patient has had an initial Special Authority approval for patient for	aliperidone once-monthly depot injection
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate) O The initiation of paliperidone depot injection has been associated wi corresponding period of time prior to the initiation of an atypical antiparticity	

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:
Olanzapine	

CONTINUATION

Re-assessment required after 12 months Prerequisites (tick box where appropriate)

> \bigcirc The initiation of olanzapine depot injection has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of an atypical antipsychotic depot injection

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:

Risperidone

sses	smer		uired after 12 months poxes where appropriate)
or	0		patient has had an initial Special Authority approval for paliperidone depot injection or olanzapine depot injection or aripiprazole t injection
	an	O d	The patient has schizophrenia or other psychotic disorder
	an	O d	The patient has not been able to adhere to treatment using oral atypical antipsychotic agents
		0	The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in the last 12 months

CONTINUATION

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

The initiation of risperidone depot injection has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of an atypical antipsychotic depot injection \bigcirc

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:

Aripiprazole

	(or	O The patient has had an initial Special Authority approval for risperidone depot injection or paliperidone depot injection or olanzapine depot injection
		O The patient has schizophrenia or other psychotic disorder
		The patient has received treatment with oral atypical antipsychotic agents but has been unable to adhere
		The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in last 12 months
or		Patient has been unable to access olanzapine depot injection due to supply issues with olanzapine depot injection, or otherwise would have been initiated on olanzapine depot injection but has been unable to due to supply issues with olanzapine depot injection. (see

- All of the following:
 - The patient has schizophrenia; and
 - The patient has tried but has not been able to adhere with treatment using oral atypical antipsychotic agents; and
 - The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in the last 12 months.

and

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	PATIENT:
Name:	Name:
Ward:	NHI:
Diazepam	
INITIATION Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a relevant specialist, or in accord Hospital.	dance with a protocol or guideline that has been endorsed by the Health NZ

Only for use in children where diazepam tablets are not appropriate

SCRIB	ER	PATIENT:	
e:		Name:	
:		NHI:	
iple S	Scler	is	
IATION teriflu assessi requisi	I – Mu nomic ment r tes (tie	ble Sclerosis - dimethyl fumarate, fingolimod, glatiramer acetate, interferon beta-1-alpha, interferon beta-1-beta, nata nired after 12 months boxes where appropriate)	
	IZ Hos	by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by th al.	ie Hea
	(and	Diagnosis of multiple sclerosis (MS) meets the McDonald 2017 diagnostic criteria for MS and has been confirmed by a neurologist	
	(and	Patient has an EDSS score between 0 – 6.0	
	(and	Patient has had at least one significant attack of MS in the previous 12 months or two significant attacks in the past 24 months attacks in the past 24 months attack of MS in the previous 12 months attack of MS in the previous 12 months attacks in the past 24 months attack of MS in the previous 12 months attack attack attacks attack of MS in the previous 12 months attack attack attacks a	nths
		 Each significant attack must be confirmed by the applying neurologist or general physician (the patient may not necessarily have been seen by them during the attack, but the neurologist/physician must be satisfied that the clinica features were characteristic) Each significant attack is associated with characteristic new symptom(s)/sign(s) or substantially worsening of previou experienced symptoms(s)/sign(s) 	
		D Each significant attack has lasted at least one week and has started at least one month after the onset of a previous attack (where relevant)	
		Each significant attack can be distinguished from the effects of general fatigue; and is not associated with a fever (T> 37.5°C)	
		O Each significant attack is severe enough to change either the EDSS or at least one of the Kurtze Functional System scores by at least 1 point	
		O Each significant attack is a recurrent paroxysmal symptom of multiple sclerosis (tonic seizures/spasms, trigeminal neuralgia, Lhermitte's symptom)	
	and (and	Evidence of new inflammatory activity on an MRI scan within the past 24 months	
		 A sign of that new inflammatory activity on MRI scanning (in criterion 5 immediately above) is a gadolinium enhancing lesion A sign of that new inflammatory activity is a lesion showing diffusion restriction 	g
		O A sign of that new inflammatory is a T2 lesion with associated local swelling	
		O A sign of that new inflammatory activity is a prominent T2 lesion that clearly is responsible for the clinical features of a recent attack that occurred within the last 2 years	a
		${ m O}$ A sign of that new inflammatory activity is new T2 lesions compared with a previous MRI scan	

Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.

()

and

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	PATIENT:
Name:	Name:
Ward:	NHI:

Multiple Sclerosis - continued

CONTINUATION - Multiple Sclerosis - dimethyl fumarate, fingolimod, glatiramer acetate, interferon beta-1-alpha, interferon beta-1-beta, natalizumab and teriflunomide

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

Patient has had an EDSS score of 0 to 6.0 (inclusive) with or without the use unilateral or bilateral aids at any time in the last six months (ie the patient has walked 100 metres or more with or without aids in the last six months) Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.

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.	

SCRIBER	PATIENT:
e:	
I:	NHI:
tiple Sclerosis	
Assessment required a requisites (tick boxes O Prescribed by, control NZ Hospital.	
and	rologist ent has an EDSS score between 0 – 6.0
and and and and and and and o	ent has had at least one significant attack of MS in the previous 12 months or two significant attacks in the past 24 months Each significant attack must be confirmed by the applying neurologist or general physician (the patient may not necessarily have been seen by them during the attack, but the neurologist/physician must be satisfied that the clinical features were characteristic) Each significant attack is associated with characteristic new symptom(s)/sign(s) or substantially worsening of previously experienced symptoms(s)/sign(s) Each significant attack has lasted at least one week and has started at least one month after the onset of a previous attack (where relevant) Each significant attack can be distinguished from the effects of general fatigue; and is not associated with a fever (T> 37.5°C) C Each significant attack is severe enough to change either the EDSS or at least one of the Kurtze Functional System scores by at least 1 point. C Each significant attack is a recurrent paroxysmal symptom of multiple sclerosis (tonic seizures/spasms, trigeminal neuralgia, Lhermitte's symptom)
and end or or or or or	dence of new inflammatory activity on an MRI scan within the past 24 months A sign of that new inflammatory activity on MRI scanning (in criterion 5 immediately above) is a gadolinium enhancing lesion A sign of that new inflammatory activity is a lesion showing diffusion restriction A sign of that new inflammatory is a T2 lesion with associated local swelling A sign of that new inflammatory activity is a prominent T2 lesion that clearly is responsible for the clinical features of a recent attack that occurred within the last 2 years A sign of that new inflammatory activity is new T2 lesions compared with a previous MRI scan

Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.

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.		
PRES	CRIBER	PATIENT:
Name		Name:
Ward:		NHI:
Multiple Sclerosis - continued		
CONTINUATION – Multiple Sclerosis - ocrelizumab Prerequisites (tick box where appropriate)		
O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and		
O Patient has had an EDSS score of 0 to 6.0 (inclusive) with or without the use unilateral or bilateral aids at any time in the last six months (ie the patient has walked 100 metres or more with or without aids in the last six months) Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.		
INITIATION – Primary Progressive Multiple Sclerosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and		
	O Diagnosis of primary progressive multiple sclerosis (PPMS) meets the 2017 McDonald criteria and has been confirmed by a neurologist	
	m O Patient has an EDSS 2.0 (score equal to or greater than 2 on pyramidal functions) to EDSS 6.5	
	And O Patient has no history of relapsing remitting multiple sclerosis	
CONTINUATION – Primary Progressive Multiple Sclerosis Prerequisites (tick box where appropriate)		
and	Prescribed by, or recommended by any relevant practitioner, or in a NZ Hospital.	ccordance with a protocol or guideline that has been endorsed by the Health
and	${\sf D}$ Patient has had an EDSS score of less than or equal to 6.5 at any t	ime in the last six months (ie patient has walked 20 metres with bilateral

assistance/aids, without rest in the last six months)

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:		
Melatonin			
INITIATION – insomnia secondary to neurodevelopmental disc Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a psychiatrist, paedia guideline that has been endorsed by the Health NZ Hosp and O Patient has been diagnosed with persistent and dis limited to, autism spectrum disorder or attention de and O Behavioural and environmental approaches have to and O Funded modified-release melatonin is to be given a and O Patient is aged 18 years or under CONTINUATION – insomnia secondary to neurodevelopmenta Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	atrician, neurologist or respiratory specialist, or in accordance with a protocol or oital. stressing insomnia secondary to a neurodevelopmental disorder (including, but not efficit hyperactivity disorder) been tried or are inappropriate at doses no greater than 10 mg per day		
and O Patient has had a trial of funded modified-release repersistent and distressing insomnia and O Funded modified-release melatonin is to be given a			
INITIATION – insomnia where benzodiazepines and zopicione are contraindicated Prerequisites (tick boxes where appropriate)			
Patient has insomnia and benzodiazepines and zo and O For in-hospital use only	piclone are contraindicated		

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:

Nusinersen

INITIATION Re-assessment required after 12 months						
Prerequisi	tes (tick boxes where appropriate)					
(O Patient has genetic documentation of homozygous SMN1 gene deletion, homozygous SMN1 point mutation, or compound heterozygous mutation					
and (and	D Patient is 18 years of age or under					
	O Patient has experienced the defined signs and symptoms of SMA type I, II or IIIa prior to three years of age or					
	O Patient is pre-symptomatic					
	O Patient has three or less copies of SMN2					
CONTINUA Re-assessr	TION nent required after 12 months					
Prerequisi	tes (tick boxes where appropriate)					
(and	C There has been demonstrated maintenance of motor milestone function since treatment initiation					
(Patient does not require invasive permanent ventilation (at least 16 hours per day), in the absence of a potentially reversible cause while being treated with nusinersen					
and (D Nusinersen not to be administered in combination other SMA disease modifying treatments or gene therapy					

I confirm that the above details are c	orrect:
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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:

Risdiplam

	I nent required after 12 months
	tes (tick boxes where appropriate)
(and	Patient has genetic documentation of homozygous SMN1 gene deletion, homozygous SMN1 point mutation, or compound heterozygous mutation
and	O Patient is 18 years of age or under
	O Patient has experienced the defined signs and symptoms of SMA type I, II or IIIa prior to three years of age or
	O Patient is pre-symptomatic
	O Patient has three or less copies of SMN2
	ATION ment required after 12 months
	tes (tick boxes where appropriate)
(and	O There has been demonstrated maintenance of motor milestone function since treatment initiation
(Patient does not require invasive permanent ventilation (at least 16 hours per day), in the absence of a potentially reversible cause while being treated with risdiplam
and (O Risdiplam not to be administered in combination other SMA disease modifying treatments or gene therapy

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:

Modafinil

)N – Na sites (ti		lepsy poxes where appropriate)
			by, or recommended by a neurologist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed Ith NZ Hospital.
	O The patient has a diagnosis of narcolepsy and has excessive daytime sleepiness associated with narcolepsy occurring almost daily for three months or more and		
		or	 O The patient has a multiple sleep latency test with a mean sleep latency of less than or equal to 10 minutes and 2 or more sleep onset rapid eye movement periods O The patient has at least one of: cataplexy, sleep paralysis or hypnagogic hallucinations
	and	or	 An effective dose of a listed formulation of methylphenidate or dexamphetamine has been trialled and discontinued because of intolerable side effects Methylphenidate and dexamphetamine are contraindicated
or	(and	C C	Patient meets the Hospital Restriction criteria for methylphenidate hydrochloride for narcolepsy Patient is unable to access methylphenidate hydrochloride presentations due to an out of stock (see note)

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:

Lisdexamfetamine dimesilate

INITIATION

Prerequisites (tick boxes where appropriate)

()Prescribed by, or recommended by a paediatrician or psychiatrist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and

(and	С	ADHD (Attention Deficit and Hyperactivity Disorder)
and (С	Diagnosed according to DSM-V or ICD 11 criteria
		O Patient is taking a currently subsidised formulation of atomoxetine or methylphenidate hydrochloride (extended-release) and has not received sufficient benefit or has experienced intolerable side effects
	or	O Patient is taking a currently subsidised formulation of dexamfetamine sulfate (immediate-release) which has not been effective due to significant administration and/or treatment adherence difficulties
	or or	\circ O There is significant concern regarding the risk of diversion or abuse of immediate release dexamfetamine sulfate
		O Patient is taking a currently subsidised formulation of methylphenidate hydrochloride (immediate-release or sustained release) which has not been effective due to significant administration and/or treatment adherence difficulties
	or or	O There is significant concern regarding the risk of diversion or abuse of immediate release methylphenidate hydrochloric
		O Patient would have been prescribed a subsidised formulation of methylphenidate hydrochloride (extended-release) but has been unable to access due to supply issues with methylphenidate hydrochloride (extended-release) and
		O Other alternative stimulant presentations (methylphenidate or dexamfetamine) are not appropriate

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.

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Methylphenidate hydrochloride			
INITIATION – ADHD (immediate-release and sustained-release formulation Prerequisites (tick box where appropriate)	ons)		
Health NZ Hospital.	r in accordance with a protocol or guideline that has been endorsed by the		
Patient has ADHD (Attention Deficit and Hyperactivity Disorder), dia	gnosed according to DSM-IV or ICD 10 criteria		
INITIATION – Narcolepsy (immediate-release and sustained-release form Prerequisites (tick box where appropriate)	ulations)		
O Prescribed by, or recommended by a neurologist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
O Patient suffers from narcolepsy			
INITIATION – Extended-release and modified-release formulations Prerequisites (tick boxes where appropriate)			
O Prescribed by, or recommended by a paediatrician or psychiatrist, o Health NZ Hospital.	r in accordance with a protocol or guideline that has been endorsed by the		
Patient has ADHD (Attention Deficit and Hyperactivity Disorde	r), diagnosed according to DSM-IV or ICD 10 criteria		
O Patient is taking a currently listed formulation of methylp has not been effective due to significant administration a	henidate hydrochloride (immediate-release or sustained-release) which and/or compliance difficulties		
	on or abuse of immediate-release methylphenidate hydrochloride		
INITIATION – Narcolepsy* (extended-release only) Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by a neurologist or respiratory spec by the Health NZ Hospital.	ialist, or in accordance with a protocol or guideline that has been endorsed		

and

O Patient suffers from narcolepsy

Note: *narcolepsy is not a registered indication for Concerta or Ritalin LA.

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.

PRESCR	IBER	PATIENT:			
Name:		Name:			
Ward:		NHI:			
Dexam	phetamine sulphate				
	ON – ADHD isites (tick box where appropriate)				
and	O Prescribed by, or recommended by a paediatrician or psychiatrist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
	O Patient has ADHD (Attention Deficit and Hyperactivity Disorder), diagnosed according to DSM-IV or ICD 10 criteria				
INITIATION – Narcolepsy					
Prerequisites (tick box where appropriate)					
0	Prescribed by, or recommended by a neurologist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
O Patient suffers from narcolepsy					

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:
Rivastigmine	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O The patient has been diagnosed with dementia and O The patient has experienced intolerable nausea and/or vomiting	ng from donepezil tablets
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O The treatment remains appropriate and O The patient has demonstrated a significant and sustained ben	efit from treatment

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:	
Naltrexone hydrochloride		
INITIATION – Alcohol dependence Prerequisites (tick boxes where appropriate)		
O Patient is currently enrolled, or is planned to be enrolled, in and O Naltrexone is to be prescribed by, or on the recommendation	a recognised comprehensive treatment programme for alcohol dependence on of, a physician working in an Alcohol and Drug Service	
INITIATION – Constipation Prerequisites (tick box where appropriate)		
O For the treatment of opioid-induced constipation		

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.

PRES	CRI	BER		PATIENT:
Name	:			Name:
Ward:				NHI:
Nico	tine	9		
INITI Prere			(tick boxes where appropriate)	
	or		For perioperative use in patients who have a 'nil by mouth' inst	ruction
	or	0	For use within mental health inpatient units	
O Patient would be admitted to a mental health inpatient unit, but is unable to due to COVID-19 self-isolation requirement or		t is unable to due to COVID-19 self-isolation requirement		
		0	For acute use in agitated patients who are unable to leave the	hospital facilities

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:

Varenicline

NITIATION Prerequisites (tick boxes where appropriate)				
	0	Short-term therapy as an aid to achieving abstinence in a patient who has indicated that they are ready to cease smoking		
and	0	The patient is part of, or is about to enrol in, a comprehensive support and counselling smoking cessation programme, which includes prescriber or nurse monitoring		
		O The patient has tried but failed to quit smoking after at least two separate trials of nicotine replacement therapy, at least one of which included the patient receiving comprehensive advice on the optimal use of nicotine replacement therapy		
	or	O The patient has tried but failed to quit smoking using bupropion or nortriptyline		
and	Ο	The patient has not had a Special Authority for varenicline approved in the last 6 months		
and	Ο	Varenicline is not to be used in combination with other pharmacological smoking cessation treatments and the patient has agreed to this		
	Ο	The patient is not pregnant		
and	Ο	The patient will not be prescribed more than 12 weeks' funded varenicline in a 12 month period		

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:
Buprenorphine with naloxone	
INITIATION – Detoxification Prerequisites (tick boxes where appropriate) O Patient is opioid dependent and O Patient is currently engaged with an opioid treatment service and O Prescriber works in an opioid treatment service approved by the	
INITIATION – Maintenance treatment Prerequisites (tick boxes where appropriate) O Patient is opioid dependent and O Patient will not be receiving methadone and O Patient is currently enrolled in an opioid substitution treatment and O Prescriber works in an opioid treatment service approved by the	

Oncology Agents and Immunosuppressants

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.

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.

PRESCRI	BER	PAT	IENT:
Name:		Nar	ne:
Ward:		NHI	:
Bendam	ustine h	nydrochloride - continued	
Re-asses	sment requ	Indolent, Low-grade lymphomas uired after 9 months boxes where appropriate)	
	and	Patient is refractory to or has relapsed within 12 months of rite	uximab in combination with bendamustine
	Ο	Bendamustine is to be administered in combination with obinu	utuzumab for a maximum of 6 cycles
or	Ο	Patients have not received a bendamustine regimen within the	e last 12 months

and

Bendamustine is to be administered for a maximum of 6 cycles in relapsed patients (in combination with rituximab when CD20+)

Patient has had a rituximab treatment-free interval of 12 months or more

Bendamustine is to be administered as a monotherapy for a maximum of 6 cycles in rituximab refractory patients

Note: 'indolent, low-grade lymphomas' includes follicular, mantle cell, marginal zone and lymphoplasmacytic/ Waldenström's macroglobulinaemia.

INITIATION – Hodgkin's lymphoma*

and

or

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

and

 \bigcirc

Patient has Hodgkin's lymphoma requiring treatment
 and
 Patient has a ECOG performance status of 0-2

and O Patient has received one prior line of chemotherapy

and O Patient's disease relapsed or was refractory following prior chemotherapy

O Bendamustine is to be administered in combination with gemcitabine and vinorelbine (BeGeV) at a maximum dose of no greater than 90 mg/m2 twice per cycle, for a maximum of four cycles

Note: Indications marked with * are unapproved indications.

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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:

Azacitidine

_						
Re-	INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)					
and	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.					
		or or	0 0 0	The patient has International Prognostic Scoring System (IPSS) intermediate-2 or high risk myelodysplastic syndrome The patient has chronic myelomonocytic leukaemia (10%-29% marrow blasts without myeloproliferative disorder) The patient has acute myeloid leukaemia with 20-30% blasts and multi-lineage dysplasia, according to World Health Organisation Classification (WHO)		
	and and	Ο		patient has performance status (WHO/ECOG) grade 0-2 patient has an estimated life expectancy of at least 3 months		
CO)N			

ONTINUATION

Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)

and

 \bigcirc

O No evidence of disease progression

The treatment remains appropriate and patient is benefitting from treatment

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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Mercaptopurine	
INITIATION Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a paediatric haematologist or pabeen endorsed by the Health NZ Hospital. and O The patient requires a total dose of less than one full 50 mg tablet p	ediatric oncologist, or in accordance with a protocol or guideline that has er day
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a paediatric haematologist or pabeen endorsed by the Health NZ Hospital. and O The patient requires a total dose of less than one full 50 mg tablet p	ediatric oncologist, or in accordance with a protocol or guideline that has er day
I he patient requires a total dose of less than one full 50 mg tablet p	er day

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:
Venetoclax	
INITIATION – relapsed/refractory chronic lymphocytic leukaemia Re-assessment required after 7 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a haematologist, or in accordance Hospital. and O Patient has chronic lymphocytic leukaemia requiring treatment and O Patient has received at least one prior therapy for chronic lymphocytic leukaemia requiring treatment and O Patient has not previously received funded venetoclax and O The patient's disease has relapsed within 36 months of previous and	phocytic leukaemia
and Hospital.	is of treatment following the titration schedule unless earlier discontinuation
INITIATION – previously untreated chronic lymphocytic leukaemia with 1 Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a haematologist, or in accordance Hospital. and O Patient has previously untreated chronic lymphocytic leukaem and O There is documentation confirming that patient has 17p deletion and O Patient has an ECOG performance status of 0-2	ce with a protocol or guideline that has been endorsed by the Health NZ
CONTINUATION – previously untreated chronic lymphocytic leukaemia of Re-assessment required after 6 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a haematologist, or in accordance Hospital. and O The treatment remains clinically appropriate and the patient is benefic Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymp marked with * are unapproved indications.	ce with a protocol or guideline that has been endorsed by the Health NZ fitting from and tolerating treatment

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:		Name:
Ward:		NHI:

Olaparib

		Dvarian cancer t required after 12 months			
Prerequis	ites	(tick boxes where appropriate)			
	O Prescribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
and	0	Patient has a high-grade serous* epithelial ovarian, fallopian tube, or primary peritoneal cancer			
and	\bigcirc	There is documentation confirming pathogenic germline BRCA1 or BRCA2 gene mutation			
		O Patient has newly diagnosed, advanced disease			
		O Patient has received one line** of previous treatment with platinum-based chemotherapy and			
		O Patient's disease must have experienced a partial or complete response to the first-line platinum-based regimen			
	or				
		O Patient has received at least two lines** of previous treatment with platinum-based chemotherapy and			
		O Patient has platinum sensitive disease defined as disease progression occurring at least 6 months after the last dose of the penultimate line** of platinum-based chemotherapy			
		and			
		O Patient's disease must have experienced a partial or complete response to treatment with the immediately preceding platinum-based regimen			
		and			
		O Patient has not previously received funded olaparib treatment			
and	\square				
and	Ο	Treatment will be commenced within 12 weeks of the patient's last dose of the immediately preceding platinum-based regimen			
	Ο	Treatment to be administered as maintenance treatment			
and	Ο	Treatment not to be administered in combination with other chemotherapy			

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	CRIB	ER	PATIENT:
Name:			Name:
Ward:			NHI:
Olapa	irib	- <i>CO</i>	ntinued
Re-ass Prerec	sessi quisi) P	nent tes (N – Ovarian cancer required after 12 months (tick boxes where appropriate) ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ tal.
and	(and	С	Treatment remains clinically appropriate and patient is benefitting from treatment
		or	 No evidence of progressive disease Evidence of residual (not progressive) disease and the patient would continue to benefit from treatment in the clinician's opinion
4	and (and (and		Treatment to be administered as maintenance treatment Treatment not to be administered in combination with other chemotherapy
			 Patient has received one line** of previous treatment with platinum-based chemotherapy and Documentation confirming that the patient has been informed and acknowledges that the funded treatment period of olaparib will not be continued beyond 2 years if the patient experiences a complete response to treatment and there is no radiological evidence of disease at 2 years
		or	O Patient has received at least two lines** of previous treatment with platinum-based chemotherapy

Note: *Note "high-grade serous" includes tumours with high-grade serous features or a high-grade serous component **A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments.

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:
Ibrutinib	

) (Patient has chronic lymphocytic leukaemia (CLL) requiring therapy
and) (Patient has not previously received funded ibrutinib
and) (brutinib is to be used as monotherapy
		O There is documentation confirming that patient has 17p deletion or TP53 mutation
		O Patient has experienced intolerable side effects with venetoclax monotherapy
	or	
		O Patient has received at least one prior immunochemotherapy for CLL
		and Patient's CLL has released within 36 menths of provisus treatment
		 Patient's CLL has relapsed within 36 months of previous treatment and
		O Patient has experienced intolerable side effects with venetoclax in combination with rituximab regimen
	or	
		m O Patient's CLL is refractory to or has relapsed within 36 months of a venetoclax regimen
		N – chronic lymphocytic leukaemia (CLL)
		required after 12 months
requisit	es (1	tick boxes where appropriate)

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL) and B-cell prolymphocytic leukaemia (B-PLL)*. Indications marked with * are Unapproved indications.

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:	

Niraparib

	essme	nt required after 6 months (tick boxes where appropriate)
a a a a		Patient has advanced high-grade serous* epithelial ovarian, fallopian tube, or primary peritoneal cancer Patient has received at least one line** of treatment with platinum-based chemotherapy Patient has experienced a partial or complete response to the preceding treatment with platinum-based chemotherapy Patient has not previously received funded treatment with a PARP inhibitor O Treatment will be commenced within 12 weeks of the patient's last dose of the preceding platinum-based regimen O Patient commenced treatment with niraparib prior to 1 May 2024 Treatment to be administered as maintenance treatment Treatment not to be administered in combination with other chemotherapy
Prereq	essme	nt required after 6 months (tick boxes where appropriate) No evidence of progressive disease Treatment to be administered as maintenance treatment Treatment not to be administered in combination with other chemotherapy O Treatment with niraparib to cease after a total duration of 36 months from commencement

Note: * "high-grade serous" includes tumours with high-grade serous features or a high-grade serous component. **A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments

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 th	e Pharmaceutical
Schedule. For community funding, see the Special Authority Criteria.			

PRESCRIBER		PATIENT:
Name:		Name:
Ward:		NHI:
Lenalidomide		
INITIATION – Plasma cell dyscrasia Prerequisites (tick boxes where appro	ppriate)	
Prescribed by, or recommend NZ Hospital.	led by any relevant practitioner, or in ac	ccordance with a protocol or guideline that has been endorsed by the Health
and		macroglobulinaemia, requiring treatment
O Patient is not refractory	/ to prior lenalidomide use	
INITIATION – Myelodysplastic synda Re-assessment required after 6 month Prerequisites (tick boxes where appro O Prescribed by, or recommend NZ Hospital.	is opriate)	ccordance with a protocol or guideline that has been endorsed by the Health
Patient has low or inter a deletion 5q cytogene		me (based on IPSS or an IPSS-R score of less than 3.5) associated with
O Patient has transfusior	-dependent anaemia	
CONTINUATION – Myelodysplastic syndrome Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Patient has not needed a transfusion in the last 4 months		
O No evidence of diseas	e progression	

and

and ()

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and \bigcirc

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	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Pomalidomide			
INITIATION – Relapsed/refractory plasma cell dyscrasia Re-assessment required after 6 months			

Prerequisites (tick boxes where appropriate)

Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

O Patient has relapsed or refractory plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment

Patient has not received prior funded pomalidomide

CONTINUATION - Relapsed/refractory plasma cell dyscrasia

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

Patient has no evidence of disease progression

Use this checklist to determine if a patient meets the restrictions for funding in the Schedule. For community funding, see the Special Authority Criteria.	he hospital setting . For more details, refer to Section H of the Pharmaceutical
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Temozolomide	
INITIATION – gliomas Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Patient has a glioma	
CONTINUATION – gliomas Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Treatment remains appropriate and patient is benefitting from treatm	nent
INITIATION – Neuroendocrine tumours Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)	
 Patient has been diagnosed with metastatic or unresectable wand Temozolomide is to be given in combination with capecitabine and Temozolomide is to be used in 28 day treatment cycles for a r per day Temozolomide to be discontinued at disease progression 	
CONTINUATION – Neuroendocrine tumours Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O No evidence of disease progression and O The treatment remains appropriate and the patient is benefitti	ng from treatment
INITIATION – ewing's sarcoma Re-assessment required after 9 months Prerequisites (tick box where appropriate) O Patient has relapse or refractory Ewing's sarcoma	
CONTINUATION – ewing's sarcoma Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O No evidence of disease progression and O The treatment remains appropriate and the patient is benefitti	ng from treatment
Note: Indication marked with a * is an unapproved indication. Temozolomic relapsed high grade glioma.	de is not funded for the treatment of

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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Thalidomide	
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	

O The patient has plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment

The patient has erythema nodosum leprosum

CONTINUATION

or

Prerequisites (tick box where appropriate)

O Patient has obtained a response from treatment during the initial approval period Note: Prescription must be written by a registered prescriber in the thalidomide risk management programme operated by the supplier Maximum dose of 400 mg daily as monotherapy or in a combination therapy regimen

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:	
Bortezomib		
INITIATION – plasma cell dyscrasia		

Prerequisites (tick box where appropriate)

m O The patient has plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment

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:
Pegaspargase	
INITIATION – Newly diagnosed ALL Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
O The patient has newly diagnosed acute lymphoblastic leukaer and O Pegaspargase to be used with a contemporary intensive multi	
INITIATION – Relapsed ALL Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
O The patient has relapsed acute lymphoblastic leukaemia and O Pegaspargase to be used with a contemporary intensive multi	-agent chemotherapy treatment protocol
INITIATION – Lymphoma Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Patient has lymphoma requiring L-asparaginase containing protocol	(e.g. SMILE)

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:	
N11 - 11-11		

Nilotinib

Re-a		N ment required after 6 months ites (tick boxes where appropriate)
(and		Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ lospital.
	and	O Patient has a diagnosis of chronic myeloid leukaemia (CML) in blast crisis, high risk chronic phase, or in chronic phase
		O Patient has documented CML treatment failure* with a tyrosine kinase inhibitor (TKI)
		O Patient has experienced treatment limiting toxicity with a tyrosine kinase inhibitor (TKI) precluding further treatment
	and	O Maximum nilotinib dose of 800 mg/day
	anu	O Subsidised for use as monotherapy only
Note	: *trea	atment failure as defined by Leukaemia Net Guidelines.
Re-a	ssess	ATION ment required after 6 months ites (tick boxes where appropriate)
(and		Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ lospital.
	and	O Lack of treatment failure while on nilotinib as defined by Leukaemia Net Guidelines
	and	O Nilotinib treatment remains appropriate and the patient is benefiting from treatment
	and	O Maximum nilotinib dose of 800 mg/day
	(O Subsidised for use as monotherapy only

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:	

Ruxolitinib

Prerequi	smen sites	t required after 12 months (tick boxes where appropriate) cribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.
and	O or	The patient has primary myelofibrosis or post-polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis O A classification of risk of intermediate-2 or high-risk myelofibrosis according to either the International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or the Age-Adjusted DIPSS O A classification of risk of intermediate-1 myelofibrosis according to either the International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or the Age-Adjusted DIPSS and O Patient has severe disease-related symptoms that are resistant, refractory or intolerant to available therapy
CONTINI	0	A maximum dose of 20 mg twice daily is to be given

Prerequisites (tick boxes where appropriate)

()and \bigcirc

A maximum dose of 20 mg twice daily is to be given

The treatment remains appropriate and the patient is benefiting from treatment

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:
Alectinib	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	-small cell lung cancer < tyrosine kinase gene rearrangement using an appropriate ALK test
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O No evidence of progressive disease according to RECIST crite and O The patient is benefitting from and tolerating treatment	eria

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:	

Palbociclib (Ibrance)

	and	Patient has unresectable locally advanced or metastatic breast cancer
) There is documentation confirming disease is hormone-receptor positive and HER2-negative
	and	Patient has an ECOG performance score of 0-2
		O Disease has relapsed or progressed during prior endocrine therapy or
		O Patient is amenorrhoeic, either naturally or induced, with endocrine levels consistent with a postmenopausal or without menstrual-potential state
		And O Patient has not received prior systemic treatment for metastatic disease
	and	 Treatment must be used in combination with an endocrine partner Patient has not received prior funded treatment with a CDK4/6 inhibitor
or		
		Patient has an active Special Authority approval for ribociclib
	and	Patient has experienced a grade 3 or 4 adverse reaction to ribociclib that cannot be managed by dose reductions and requires treatment discontinuation
	C	C Treatment must be used in combination with an endocrine partner
	and	There is no evidence of progressive disease since initiation of ribociclib

Prerequisites (tick boxes where appropriate)

Ο and \bigcirc

Treatment must be used in combination with an endocrine partner

There is no evidence of progressive disease since initiation of palbociclib

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.

PRES	CRIBER		PATIENT:
Name:			Name:
Ward:			NHI:
Mido	staurin		
Prere	ATION quisites and and and and and	(tick boxes where appropriate) Patient has a diagnosis of acute myeloid leukaemia Condition must be FMS tyrosine kinase 3 (FLT3) mutation pos Patient must not have received a prior line of intensive chemot Patient is to receive standard intensive chemotherapy in comb	herapy for acute myeloid leukaemia
	O	Midostaurin to be funded for a maximum of 4 cycles	

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:	

Ribociclib

	ment		ired after 6 months poxes where appropriate)
	and and and	0 0 0	Patient has unresectable locally advanced or metastatic breast cancer There is documentation confirming disease is hormone-receptor positive and HER2-negative Patient has an ECOG performance score of 0-2
		or	 O Disease has relapsed or progressed during prior endocrine therapy O Patient is amenorrhoeic, either naturally or induced, with endocrine levels consistent with a postmenopausal or without menstrual-potential state and O Patient has not received prior systemic endocrine treatment for metastatic disease
	and	or	O Patient commenced treatment with ribociclib in combination with an endocrine partner prior to 1 July 2024 and O There is no evidence of progressive disease Treatment to be used in combination with an endocrine partner
or	and	0	Patient has not received prior funded treatment with a CDK4/6 inhibitor Patient has an active Special Authority approval for palbociclib Patient has experienced a grade 3 or 4 adverse reaction to palbociclib that cannot be managed by dose reductions and requires treatment discontinuation
CONTINU	and		Treatment must be used in combination with an endocrine partner There is no evidence of progressive disease since initiation of palbociclib
Re-assess	ites (t	requ ick b	ired after 12 months poxes where appropriate) ment must be used in combination with an endocrine partner
and	\cap		e is no evidence of progressive disease since initiation of ribociclib

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:

Lenvatinib

or	O Patient is currently on treatment with lenvatinib and met all remaining criteria prior to commencing treatment				
	and	O The patient has locally advanced or metastatic differentiated thyroid cancer			
			0	Patient must have symptomatic progressive disease prior to treatment	
		or	0	Patient must progressive disease at critical anatomical sites with a high risk of morbidity or mortality where local control cannot be achieved by other measures	
	and				
		O A lesion without iodine uptake in a RAI scan			
		or	Ο	Receiving cumulative RAI greater than or equal to 600 mCi	
		or	Ο	Experiencing disease progression after a RAI treatment within 12 months	
		or	Ο	Experiencing disease progression after two RAI treatments administered within 12 months of each other	
and O Patient has thyroid stimulating hormone (TSH) adequately supressed				ent has thyroid stimulating hormone (TSH) adequately supressed	
	and	\bigcirc			
	Patient is not a candidate for radiotherapy with curative intent and Surgery is clinically inappropriate				
	and	O Patient has an ECOG performance status of 0-2			

Prerequisites (tick box where appropriate)

O There is no evidence of disease progression

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:
Lenvatinib - continued	
and	from treatment with atezolizumab with bevacizumab
O No disease progression since initiation of atezoliz	umab with bevacizumab
CONTINUATION – unresectable hepatocellular carcinoma Re-assessment required after 6 months Prerequisites (tick box where appropriate) O There is no evidence of disease progression	
INITIATION – renal cell carcinoma Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	
 The patient has metastatic renal cell carcinoma The disease is of predominant clear-cell histology The patient has documented disease progression follow The patient has an ECOG performance status of 0-2 The patient has an ECOG performance status of 0-2 Lenvatinib is to be used in combination with everolimus Patient has received funded treatment with nivolumab for Patient has experienced treatment limiting toxicity from Lenvatinib is to be used in combination with everolimus There is no evidence of disease progression 	or the second line treatment of metastatic renal cell carcinoma
CONTINUATION – renal cell carcinoma Re-assessment required after 4 months Prerequisites (tick box where appropriate) O There is no evidence of disease progression	

Signed:	Date:
- 5	

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:

Osimertinib

INITIATION – NSCLC – first line Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)
O Patient has locally advanced or metastatic, incurable, non-squamous non-small cell lung cancer (NSCLC) and
O Patient is treatment naïve
O Patient has received prior treatment in the adjuvant setting and/or while awaiting EGFR results or
O The patient has discontinued gefitinib or erlotinib due to intolerance and
O The cancer did not progress while on gefitinib or erlotinib
and O There is documentation confirming that the cancer expresses activating mutations of EGFR and
O Patient has an ECOG performance status 0-3 and
O Baseline measurement of overall tumour burden is documented clinically and radiologically
CONTINUATION - NSCLC - first line Re-assessment required after 6 months Prerequisites (tick box where appropriate) O Response to or stable disease with treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period
INITIATION – NSCLC – second line Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)
O Patient has locally advanced or metastatic, incurable, non-squamous non-small cell lung cancer (NSCLC) and
O Patient has an ECOG performance status 0-3
O The patient must have received previous treatment with erlotinib or gefitinib and
O There is documentation confirming that the cancer expresses T790M mutation of EGFR following progression on or after erlotinib or gefitinib
and O The treatment must be given as monotherapy
and O Baseline measurement of overall tumour burden is documented clinically and radiologically

CONTINUATION – NSCLC – second line Re-assessment required after 6 months

()

Prerequisites (tick box where appropriate)

Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period

I confirm that the above details are correct:

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:
Axitinib	
INITIATION Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	
 The patient has metastatic renal cell carcinoma The disease is of predominant clear cell histology and The patient has documented disease progression following or and The patient has ECOG performance status of 0-2 	ne previous line of treatment
CONTINUATION Re-assessment required after 4 months Prerequisites (tick box where appropriate)	

O No evidence of disease progression.

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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:
Crizotinib	

Re-a		nt required after 6 months (tick boxes where appropriate)
	O	Patient has locally advanced or metastatic, unresectable, non-squamous non-small cell lung cancer
	and	There is documentation confirming that the patient has a ROS1 rearrangement using an appropriate ROS1 test
	Ο	Patient has ECOG performance score of 0-3
	and	Baseline measurement of overall tumour burden is documented clinically and radiologically
CONTINUATION		

Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)

> and \bigcirc

 \bigcirc Response to treatment has been determined by comparable radiological assessment following the most recent treatment period

No evidence of disease progression.

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:

Dasatinib

INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)
Prescribed by, or recommended by a haematologist or any relevant practitioner on the recommendation of a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O The patient has a diagnosis of chronic myeloid leukaemia (CML) in blast crisis or accelerated phase O The patient has a diagnosis of Philadelphia chromosome-positive acute lymphoid leukaemia (Ph+ ALL) or O The patient has a diagnosis of CML in chronic phase and O Patient has documented treatment failure* with imatinib or O Patient has experienced treatment-limiting toxicity with imatinib precluding further treatment with imatinib or O Patient has high-risk chronic-phase CML defined by the Sokal or EURO scoring system
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a haematologist or any relevant practitioner on the recommendation of a haematologist , or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Lack of treatment failure while on dasatinib* and O Dasatinib treatment remains appropriate and the patient is benefiting from treatment
Note: *treatment failure for CML as defined by Leukaemia Net Guidelines.

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:
m 1 -1 -1	

Erlotinib

	smen	ent required after 4 months s (tick boxes where appropriate)
and (and	0 0	 Patient has locally advanced or metastatic, unresectable, non-squamous Non Small Cell Lung Cancer (NSCLC) There is documentation confirming that the disease expresses activating mutations of EGFR
	or	m O Patient has received prior treatment in the adjuvant setting and/or while awaiting EGFR results

CONTINUATION

Re-assessment required after 6 months

Prerequisites (tick box where appropriate)

O Radiological assessment (preferably including CT scan) indicates NSCLC has not progressed

I confirm that the above details are correct:

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:
Sunitinib	
INITIATION – RCC	
Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	
O The patient has metastatic renal cell carcinoma and O The patient has not previously received funded sunitinib	
CONTINUATION – RCC Re-assessment required after 4 months Prerequisites (tick box where appropriate) O No evidence of disease progression	
INITIATION – GIST Re-assessment required after 3 months Prerequisites (tick boxes where appropriate)	
O The patient has unresectable or metastatic malignant gastroin and O The patient's disease has progressed following treatmer or O The patient has documented treatment-limiting intoleran	nt with imatinib
CONTINUATION – GIST Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
The patient has responded to treatment or has stable disease a follows:	s determined by Choi's modified CT response evaluation criteria as
(HU) of 15% or more on CT and no new lesions and no	ze of 10% or more or decrease in tumour density in Hounsfield Units obvious progression of non-measurable disease) ne two above) and does not have progressive disease and no
and The treatment remains appropriate and the patient is benefitin	g from treatment
CONTINUATION – GIST pandemic circumstances Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O The patient has unresectable or metastatic malignant gastroin	testinal stromal tumour (GIST)

The patient is clinically benefiting from treatment and continued treatment remains appropriate and

Sunitinib is to be discontinued at progression

The regular renewal requirements cannot be met due to COVID-19 constraints on the health sector

I confirm that the above details are correct:

and

()

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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:

Sunitinib - continued

Note: GIST - It is recommended that response to treatment be assessed using Choi's modified CT response evaluation criteria (J Clin Oncol, 2007, 25:1753-1759). Progressive disease is defined as either: an increase in tumour size of 10% or more and not meeting criteria of partial response (PR) by tumour density (HU) on CT; or: new lesions, or new intratumoral nodules, or increase in the size of the existing intratumoral nodules.

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:		Name:
Ward: .		NHI:
Lapati	nib	
INITIAT Prereq	TON uisites (tick box where appropriate) For continuation use only	
Re-ass	NUATION essment required after 12 months uisites (tick boxes where appropriate)	
	 The patient has metastatic breast cancer expressing HER-2 IF The cancer has not progressed at any time point during the print Lapatinib not to be given in combination with trastuzumab 	
a	D Lapatinib to be discontinued at disease progression	

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:		

Pazopanib

	sment i	•	ired after 3 months oxes where appropriate)
	(and	С	The patient has metastatic renal cell carcinoma of predominantly clear cell histology
		or	O The patient is treatment naive
			O The patient has only received prior cytokine treatment
	and (and	С	The patient has an ECOG performance score of 0-2
		[he	patient has intermediate or poor prognosis defined as:
			O Lactate dehydrogenase level > 1.5 times upper limit of normal
		or	O Haemoglobin level < lower limit of normal
		or or	O Corrected serum calcium level > 10 mg/dL (2.5 mmol/L)
		or	O Interval of < 1 year from original diagnosis to the start of systemic therapy
			O Karnofsky performance score of less than or equal to 70
		or	O 2 or more sites of organ metastasis
or			
	(and	С	The patient has metastatic renal cell carcinoma
	and	С	The patient has discontinued sunitinib within 3 months of starting treatment due to intolerance
	(С	The cancer did not progress whilst on sunitinib
	and	С	Pazopanib to be used for a maximum of 3 months
DNTINU	ATION		

Re-assessment required after 3 months **Prerequisites** (tick box where appropriate)

O No evidence of disease progression

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:		Name:		
Ward:		NHI:		

Gefitinib

INITIATION
Re-assessment required after 4 months
Prerequisites (tick boxes where appropriate)
O Patient has locally advanced, or metastatic, unresectable, non-squamous Non Small Cell Lung Cancer (NSCLC)
O Patient is treatment naive
or O Patient has received prior treatment in the adjuvant setting and/or while awaiting EGFR results or
O The patient has discontinued osimertinib or erlotinib due to intolerance and
O The cancer did not progress whilst on osimertinib or erlotinib
and
O There is documentation confirming that disease expresses activating mutations of EGFR
CONTINUATION
Re-assessment required after 6 months
Prerequisites (tick box where appropriate)

I confirm that the above details are correct:

O Radiological assessment (preferably including CT scan) indicates NSCLC has not progressed

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:		
Dexrazoxane			

I	NI	TL	AT	0	Ν	

Prer	Prerequisites (tick boxes where appropriate)				
and			cribed by, or recommended by a medical oncologist, paediatric oncologist, haematologist or paediatric haematologist, or in accordance with tocol or guideline that has been endorsed by the Health NZ Hospital.		
	(С	Patient is to receive treatment with high dose anthracycline given with curative intent		
	and O Based on current treatment plan, patient's cumulative lifetime dose of anthracycline will exceed 250mg/m2 doxorubicin eq greater		Based on current treatment plan, patient's cumulative lifetime dose of anthracycline will exceed 250mg/m2 doxorubicin equivalent or greater		
	and O Dexrazoxane to be administered only whilst on anthracycline treatment		Dexrazoxane to be administered only whilst on anthracycline treatment		
			O Treatment to be used as a cardioprotectant for a child or young adult		
		or	O Treatment to be used as a cardioprotectant for secondary malignancy		

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:		

Abiraterone acetate

INITIATION Re-assessment required after 6 months							
Prerec	Prerequisites (tick boxes where appropriate)						
and				r recommended by a medical oncologist, radiation oncologist or urologist, or in accordance with a protocol or guideline that has by the Health NZ Hospital.			
	(and	0	Patient has	s prostate cancer			
	(Ο	Patient has	s metastases			
	and (and	Ο	Patient's d	isease is castration resistant			
ſ	and						
			and	Patient is symptomatic			
			and	Patient has disease progression (rising serum PSA) after second line anti-androgen therapy			
				Patient has ECOG performance score of 0-1			
			O	Patient has not had prior treatment with taxane chemotherapy			
		or					
			and	Patient's disease has progressed following prior chemotherapy containing a taxane			
			0	Patient has ECOG performance score of 0-2			
			and	Patient has not had prior treatment with abiraterone			

CONTINUATION

Re-assessment required after 6 months	
Prerequisites (tick boxes where appropriate)	

and	0		cribed by, or recommended by a medical oncologist, radiation oncologist or urologist, or in accordance with a protocol or guideline that has endorsed by the Health NZ Hospital.
		0	Significant decrease in serum PSA from baseline
	an	Ö	No evidence of clinical disease progression
	an	d O	No initiation of taxane chemotherapy with abiraterone
	an	d O	The treatment remains appropriate and the patient is benefiting from treatment

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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:
Abiraterone acetate - continued	
CONTINUATION – pandemic circumstances Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
The patient is clinically benefiting from treatment and	d continued treatment remains appropriate
Abiraterone acetate to be discontinued at progressio	in
O No initiation of taxane chemotherapy with abirateron	e
And The regular renewal requirements cannot be met due	e to COVID-19 constraints on the health sector

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:

Fulvestrant

Re-a	INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)			
and	С	Preso Hosp	cribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.	
	an	O	Patient has oestrogen-receptor positive locally advanced or metastatic breast cancer	
		0	Patient has disease progression following prior treatment with an aromatase inhibitor or tamoxifen for their locally advanced or metastatic disease	
	and	Ο	Treatment to be given at a dose of 500 mg monthly following loading doses	
		0	Treatment to be discontinued at disease progression	

CONTINUATION

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

O Prescribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Hospital.		cribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.	
		0	Treatment remains appropriate and patient is benefitting from treatment
	and	O	Treatment to be given at a dose of 500 mg monthly
	and	1	

O No evidence of disease progression

I confirm that the above details are correct:

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:

Long-acting Somatostatin Analogues

			Malignant bowel obstruction (tick boxes where appropriate)
	and	0	The patient has nausea* and vomiting* due to malignant bowel obstruction*
	and	0	Treatment with antiemetics, rehydration, antimuscarinic agents, corticosteroids and analgesics for at least 48 hours has not been successful
	anu	Ο	Treatment to be given for up to 4 weeks
Note	: Indie	catio	ns marked with * are unapproved indications
Re-a	ssess	men	acromegaly It required after 3 months (tick boxes where appropriate)
	and	Ο	The patient has acromegaly
			O Treatment with surgery and radiotherapy is not suitable or was unsuccessful
		or	O Treatment is for an interim period while awaiting the beneficial effects of radiotherapy
	and	0	Treatment with a dopamine agonist has been unsuccessful

CONTINUATION – acromegaly

Prerequisites (tick box where appropriate)

O Without reassessment for applications where IGF1 levels have decreased since starting treatment

Note: In patients with acromegaly, treatment should be discontinued if IGF1 levels have no decreased 3 months after treatment. In patients treated with radiotherapy treatment should be withdrawn every 2 years, for 1 month, for assessment of remission. Treatment should be stopped where there is biochemical evidence of remission (normal IGF1 levels) following treatment withdrawal for at least 4 weeks.

I confirm that the above details are correct:

and

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and

and

INITIATION – pre-operative acromegaly Re-assessment required after 12 months **Prerequisites** (tick boxes where appropriate)

Patient has acromegaly

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.

PRESCRIE	RIBER PATIE	NT:
Name:	Name:	
Ward:	NHI:	
Long-act	cting Somatostatin Analogues - continued	
_	ION – Other indications uisites (tick boxes where appropriate)	
or	VIPomas and glucagonomas - for patients who are seriously ill in orde	r to improve their clinical state prior to definitive surgery
	Gastrinoma and	
	O Surgery has been unsuccessful	
	O Patient has metastatic disease after treatment with H2 ar	tagonist or proton pump inhibitors has been unsuccessful
or		
	Insulinomas and	
	O Surgery is contraindicated or has not been successful	
or	O For pre-operative control of hypoglycaemia and for maintenance thera	ру
	O Carcinoid syndrome (diagnosed by tissue pathology and/or urin	ary 5HIAA analysis)

Patient is scheduled to undergo pituitary surgery in the next six months

Patient has a large pituitary tumour, greater than 10 mm at its widest

Disabling symptoms not controlled by maximal medical therapy

Note: Indications marked with * are unapproved indications

Note: The use of a long-acting somatostatin analogue in patients with fistulae, oesophageal varices, miscellaneous diarrhoea and hypotension will not be funded under Special Authority

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:		
Aminolevulini	ic acid hydrochloride			
	gh grade malignant glioma ick boxes where appropriate)			
and P	Patient has newly diagnosed, untreated, glioblastoma multiforr	ne		
-	O Treatment to be used as adjuvant to fluorescence-guided resection			
and O P	Patient's tumour is amenable to complete resection			

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:
Tacrolimus	
INITIATION – organ transplant recipients Prerequisites (tick boxes where appropriate)	
$\begin{array}{ c c c } O & For use in organ transplant recipients \\ or & \\ O & The individual is receiving induction therapy for an organ trans$	plant
INITIATION – non-transplant indications* Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any specialist, or in accordance Hospital. and	with a protocol or guideline that has been endorsed by the Health NZ
Patient requires long-term systemic immunosuppression	
O Ciclosporin has been trialled and discontinued treatmen or O Patient is a child with nephrotic syndrome*	t because of unacceptable side effects or inadequate clinical response
Note: Indications marked with * are unapproved indications	

RS2062 - Etanercept

Arthritis - rheumatoid - INITIATION Arthritis - rheumatoid - CONTINUATION	
Adult-onset Still's disease - INITIATION	
Adult-onset Still's disease - CONTINUATION Ankylosing spondylitis - INITIATION	
Ankylosing spondylitis - CONTINUATION	
Oligoarticular course juvenile idiopathic arthritis - INITIATION Oligoarticular course juvenile idiopathic arthritis - CONTINUATION	
Polyarticular course juvenile idiopathic arthritis - INITIATION	
Polyarticular course juvenile idiopathic arthritis - CONTINUATION Psoriatic arthritis - INITIATION	
Psoriatic arthritis - CONTINUATION Pyoderma gangrenosum - INITIATION	
Pvoderma gangrenosum - CONTINUATION	
Severe chronic plaque psoriasis - CONTINUATION Severe chronic plaque psoriasis, prior TNF use - INITIATION	
Severe chronic plaque psoriasis, treatment-naive - INITIATION	
Undifferentiated spondyloarthritis - INITIATION Undifferentiated spondyloarthritis - CONTINUATION	

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 Pharmaceutica
Schedule. For community funding, see the Special Authority Criteria.		

PRESCRIBER			PATIENT:	
Name	Name:			Name:
Ward	Ward:			NHI:
Etan	erce	ept		
Re-a	asses: requis	sment sites (Presc	t requ tick b ribed	rticular course juvenile idiopathic arthritis uired after 6 months poxes where appropriate) by, or recommended by a rheumatologist or named specialist, or in accordance with a protocol or guideline that has been endorsed lth NZ Hospital.
and		and	0	The patient has had an initial Special Authority approval for adalimumab for polyarticular course juvenile idiopathic arthritis (JIA)
		une	or	 O The patient has experienced intolerable side effects from adalimumab O The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for polyarticular course JIA
	or	anc	Ο	O Moderate or high disease activity (cJADAS10 score of at least 2.5) after a 3-month trial of methotrexate (at the maximum tolerated dose)
Re-a	asses: requis	sment sites (Presc	t requ (tick b ribed	bolyarticular course juvenile idiopathic arthritis uired after 6 months boxes where appropriate) by, or recommended by a rheumatologist or named specialist, or in accordance with a protocol or guideline that has been endorsed lth NZ Hospital.
	and			tment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or erance
		or	0 0	Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baseline On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline
1			_	

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:
Etanercept - continued	
INITIATION – oligoarticular course juvenile idiopathic arthritis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a rheumatologist or named special by the Health NZ Hospital.	alist, or in accordance with a protocol or guideline that has been endorsed
and (JIA) O The patient has experienced intolerable side effect	for adalimumab for oligoarticular course juvenile idiopathic arthritis s from adalimumab dalimumab to meet the renewal criteria for adalimumab for
or To be used as an adjunct to methotrexate therapy or mor and Patient has had oligoarticular course JIA for 6 months du and	notherapy where use of methotrexate is limited by toxicity or intolerance ration or longer
or maximum tolerated dose)	pain or tenderness after a 3-month trial of methotrexate (at the e greater than 1.5) with poor prognostic features after a 3-month trial n 4) after a 6-month trial of methotrexate
CONTINUATION – oligoarticular course juvenile idiopathic arthritis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	alist, or in accordance with a protocol or guideline that has been endorsed

Subsidised as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance

Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baselinee

On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline

()

or

 \bigcirc

and

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.

PRE	SCRIB	ER			PATIENT:
Nam	e:				Name:
Ward	d:				NHI:
Etai	nerce	pt-a	conti	nued	
Re-	assess requisi	ment ites (t	requi ick b bed	red a oxes	heumatoid after 6 months where appropriate) r recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
		and	C	The	patient has had an initial Special Authority approval for adalimumab for rheumatoid arthritis
			or	0	The patient has experienced intolerable side effects The patient has received insufficient benefit to meet the renewal criteria for rheumatoid arthritis
	or	and and and and	O O O O O r	antib Trea or in Patie Patie	ent has had rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic citrullinated peptide (CCP) body positive) for six months duration or longer timent is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity tolerance ent has tried and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated) ent has tried and not responded to at least three months of methotrexate in combination with sulfasalazine and hydroxychloroquine hate at maximum tolerated doses (unless contraindicated) Patient has tried and not responded to at least three months of methotrexate in combination with the maximum tolerated dose of ciclosporin Patient has tried and not responded to at least three months of therapy at the maximum tolerated dose of leflunomide alone or in combination with methotrexate Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen joints Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip
Re-	assess requisi O P N	ment ites (t Prescri	requi ick b bed spita	red a oxes by, or	tis - rheumatoid after 2 years where appropriate) r recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
	and			rance Follo	is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or by toxicity or the patient has at least a 50% decrease in active joint count from baseline and a clinically significant onse to treatment in the opinion of the physician

O On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician

O Etanercept to be administered at doses no greater than 50 mg every 7 days

I confirm that the above details are correct:

or

and

Use this checklist to determine if a patient meets the restrictions for funding in the hospital setting	J. For more details, refer to Section H of the Pharmaceutical
Schedule. For community funding, see the Special Authority Criteria.	

PRESCRIE	BER				PATIENT:
Name:					Name:
Ward:					NHI:
Etanerce	ept - cor	ntinue	d		
Re-assess Prerequis	sment rec sites (tick	luired boxes	g spondylitis after 6 months s where appropria or recommended l	,	cordance with a protocol or guideline that has been endorsed by the Health NZ
	and	The	e patient has had	an initial Special Authority ap	proval for adalimumab for ankylosing spondylitis
		r C			e effects from adalimumab from adalimumab to meet the renewal criteria for adalimumab for
or	and and and and	Pat Pat Pat dru	ient has low back ient has bilateral s ient's ankylosing s gs (NSAIDs), in c	pain and stiffness that is relie sacroiliitis demonstrated by p spondylitis has not responded	pondylitis present for more than six months eved by exercise but not by rest lain radiographs, CT or MRI scan d adequately to treatment with two or more non-steroidal anti-inflammatory erapy if indicated, while patient was undergoing at least 3 months of a regular
	and	C	Bath Ankylosin 4 cm and lumb Patient has lim gender (see No	g Spondylitis Metrology Index ar side flexion measurement itation of chest expansion by otes)	rr spine in the sagittal and the frontal planes as determined by the following x (BASMI) measures: a modified Schober's test of less than or equal to of less than or equal to 10 cm (mean of left and right) at least 2.5 cm below the average normal values corrected for age and x (BASDAI) of at least 6 on a 0-10 scale
measure r	nust be n ormal ch Ag 18 25 35	must o mor est ex	have been detern e than 1 month o		3 month exercise trial, but prior to ceasing NSAID treatment. The BASDAI
		-64	5.5 cm	4.0 cm	

4.0 cm

3.0 cm

65-74

75+

4.0 cm

2.5 cm

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.

PRES	CRIBE	ER	PATIENT:	
Name	:		Name:	
Ward:			NHI:	
Etan	ercep	ot - c	ontinued	
Re-as	ssessr equisit	ment r tes (ti rescri ospita	 ankylosing spondylitis equired after 6 months boxes where appropriate) bed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ l. bollowing 12 weeks' initial treatment and for subsequent renewals, treatment has resulted in an improvement in BASDAI of 4 or more bints from pre-treatment baseline on a 10 point scale, or an improvement in BASDAI of 50%, whichever is less 	
	and	~	hysician considers that the patient has benefited from treatment and that continued treatment is appropriate tanercept to be administered at doses no greater than 50 mg every 7 days	
Re-as	ssessr equisit	nent r tes (ti	priatic arthritis equired after 6 months ck boxes where appropriate) ped by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ I.	
		(and	 The patient has had an initial Special Authority approval for adalimumab or secukinumab for psoriatic arthritis The patient has experienced intolerable side effects from adalimumab or secukinumab The patient has received insufficient benefit from adalimumab or secukinumab to meet the renewal criteria for adalimumab or secukinumab or secukinumab or secukinumab or secukinumab or secukinumab or secukinumab to meet the renewal criteria for adalimumab or secukinumab or secukinu	
	or	and (and (and	 Patient has had severe active psoriatic arthritis for six months duration or longer Patient has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a maximum tolerated dose Patient has tried and not responded to at least three months of sulfasalazine at a dose of at least 2 g per day or leflunomide at a dose of up to 20 mg daily (or maximum tolerated doses) Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen, tender joints 	
		and	 Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application Patient has an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour 	
			O ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months	

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.

PRES	CRIB	BER			PATIENT:			
Name	:				Name:			
Ward:					NHI:			
Etan	erce	ept -	- conti	nued				
Re-a	ssess	men	t requ	soriatic arthritis ired after 6 months oxes where appropriate)				
(and	O Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.							
	and	or	0	clinically significant response to treatment in the opinion The patient demonstrates at least a continuing 30% impr response to prior etanercept treatment in the opinion of t	rovement in active joint count from baseline and a clinically significant he treating physician			
		\bigcirc	Etane	ercept to be administered at doses no greater than 50 mg	every 7 days			
Re-a	ssess equis C F	ites	t requ (tick b cribed	e chronic plaque psoriasis, prior TNF use ired after 4 months oxes where appropriate) by, or recommended by a dermatologist, or in accordance	e with a protocol or guideline that has been endorsed by the Health NZ			
and	and	0	The p	patient has had an initial Special Authority approval for ad	alimumab for severe chronic plaque psoriasis			
			Ο	The patient has experienced intolerable side effects from	adalimumab			
		or	0	The patient has received insufficient benefit from adalimit plaque psoriasis	umab to meet the renewal criteria for adalimumab for severe chronic			
	and	0	Patie	nt must be reassessed for continuation after 3 doses				

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.

PRES	SCRIE	BER			PATIENT:					
Name	ə:				Name:					
Ward	:				NHI:					
Etan	erce	ept -	conti	nued						
				chronic plaque psoriasis, treatment-naive red after 4 months						
				oxes where appropriate)						
(and		Presc Hospi		by, or recommended by a dermatologist, or in accordance	e with a protocol or guideline that has been endorsed by the Health NZ					
	0			Patient has "whole body" severe chronic plaque psoriasis with a Psoriasis Area and Severity Index (PASI) score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis						
		or	Ο	Patient has severe chronic plaque psoriasis of the face, been present for at least 6 months from the time of initial	or palm of a hand or sole of a foot, where the plaque or plaques have diagnosis					
			0		aque psoriasis where the plaques or lesions have been present for at a Dermatology Life Quality Index (DLQI) score greater than 10					
	and and	0		nt has tried, but had an inadequate response (see Note) t ing (at maximum tolerated doses unless contraindicated)	o, or has experienced intolerable side effects from, at least three of the : phototherapy, methotrexate, ciclosporin, or acitretin					
		0	treatr		I) assessment has been completed for at least the most recent prior referably while still on treatment but no longer than 1 month following					
	and	Ο	The n	nost recent PASI or DLQI assessment is no more than 1	nonth old at the time of initiation					
while	Note: "Inadequate response" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 10, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the face, hand, foot, genital or flexural areas at least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very									

face, hand, foot, genital or flexural areas at least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very severe, and for the face, palm of a hand or sole of a foot the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment.

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:		

Etanercept - continued

CONTINUATION – severe chronic plaque psoriasis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)

			(and	O Patient had "whole body" severe chronic plaque psoriasis at the start of treatment
				 Following each prior etanercept treatment course the patient has a PASI score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-etanercept treatment baseline value Following each prior etanercept treatment course the patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, when compared with the pre-treatment baseline value
		l		
		or	(and	O Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment
			and	O Following each prior etanercept treatment course the patient has a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the treatment course baseline values
				Or Following each prior etanercept treatment course the patient has a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-etanercept treatment baseline value
		or		
			(and	O Patient had severe chronic localised genital or flexural plaque psoriasis at the start of treatment
				O The patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline value
				O Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing etanercept
	and			
		С	tanero	cept to be administered at doses no greater than 50 mg every 7 days
INIT	ATION	l – py	odern	na gangrenosum
				kes where appropriate)
(O Pro			y, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and	(ationt	has prodoma gangroposium*
	and		auent	has pyoderma gangrenosum*
				has received three months of conventional therapy including a minimum of three pharmaceuticals (e.g. prednisone, ciclosporin, prine, or methotrexate) and not received an adequate response

Note: Indications marked with * are unapproved indications.

A maximum of 8 doses

and

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.

PRES	CRIB	ER			PATIENT:		
Name	:				Name:		
Ward:					NHI:		
Etan	erce	pt -	cont	inue	ed and a second s		
CONTINUATION – pyoderma gangrenosum Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Heat Hospital.							
and	and (and (\mathbf{O}	Patie Patie	ent c	has shown clinical improvement continues to require treatment hum of 8 doses		
Re-a	ssess equisi	ites (requ tick b ribed	uired boxe	Set Still's disease d after 6 months es where appropriate) or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ		
		and	or	0	 The patient has had an initial Special Authority approval for etanercept for adult-onset Still's disease (AOSD) The patient has been started on tocilizumab for AOSD in a Health NZ Hospital The patient has experienced intolerable side effects from etanercept and/or tocilizumab The patient has received insufficient benefit from at least a three-month trial of adalimumab and/or tocilizumab such that they do not meet the renewal criteria for AOSD 		
	or	and	0	Pa an	atient diagnosed with AOSD according to the Yamaguchi criteria (J Rheumatol 1992;19:424-430) atient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, non-steroidal atient has persistent symptoms of disabling poorly controlled and active disease		
Re-a	ssess equisi	ment ites (requ tick b ribed	uired	It-onset Still's disease d after 6 months where appropriate) or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ		
and (

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.

PRES	CRIB	ER		PATIENT:
Name	:			
Ward:				NHI:
Etan	erce	pt ·	conti	inued
				erentiated spondyloarthritis ired after 6 months
				oxes where appropriate)
(and		Preso losp	by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ	
	(С		nt has undifferentiated peripheral spondyloarthritis* with active peripheral joint arthritis in at least four joints from the following: elbow, knee, ankle, and either shoulder or hip
	and (and	С		nt has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a mum tolerated dose
	(and	С	Patie dose	nt has tried and not responded to at least three months of sulfasalazine at a dose of at least 2 g per day (or maximum tolerated)
	and (and	С	Patie	nt has tried and not responded to at least three months of leflunomide at a dose of up to 20 mg daily (or maximum tolerated dose)
	O Patient has a C-reactive protein level greater than 15 mg/L m application or		0	Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application
			Ο	Patient has an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour measured no more than one month prior to the date of this application
			Ο	ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months
Note	: Indic	catio	ns ma	rked with * are unapproved indications.
Re-a	ssess	men	t requ	ndifferentiated spondyloarthritis ired after 6 months noxes where appropriate)
		or	0	Applicant is a rheumatologist
			0	Applicant is a Practitioner and confirms that a rheumatologist has provided a letter, email or fax recommending that the patient continues with etanercept treatment
	and	or	0	Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician
			Ο	The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior etanercept treatment in the opinion of the treating physician
	and (C	Etane	ercept to be administered at doses no greater than 50 mg dose every 7 days

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:

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

I confirm that the above details are correct:

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:					
Ranibizumab						
NITIATION – Wet Age Related Macular Degeneration						

(sed by the Health NZ Hospital.
		O Wet age-related macular degeneration (wet AMD)
		O Polypoidal choroidal vasculopathy
		O Choroidal neovascular membrane from causes other than wet AMD
	and	
		O The patient has developed severe endophthalmitis or severe posterior uveitis following treatment with bevacizumab
		O There is worsening of vision or failure of retina to dry despite three intraocular injections of bevacizumab four weeks apart
	and	O There is no structural damage to the central fovea of the treated eye
	and	
		O Patient has not previously been treated with aflibercept for longer than 3 months
or	O f	Patient has current approval to use aflibercept for treatment of wAMD and was found to be intolerant to aflibercept within 3 months
\subseteq		

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

O Documented benefit must be demonstrated to continue

Patient's vision is 6/36 or better on the Snellen visual acuity score

There is no structural damage to the central fovea of the treated eye

and

and

RS2065 - Infliximab

Crohn's disease (adults) - INITIATION	205
Crohn's disease (adults) - CONTINUATION	
Crohn's disease (addits) - CONTINOATION	
Crohn's disease (children) - INTIATION	
Graft vs host disease - INITIATION	
Inflammatory bowel arthritis (axial) - INITIATION	
Inflammatory bowel arthritis (axial) - CONTINUATION	
Inflammatory bowel arthritis (peripheral) - INITIATION	
Inflammatory bowel arthritis (peripheral) - CONTINUATION	
Pulmonary sarcoidosis - INITIATION	
Acute fulminant ulcerative colitis - INITIATION	
Acute fulfilinant dicertative contis - INITIATION	
Ankylosing spondylitis - CONTINUATION	
Chronic ocular inflammation - INITIATION	
Chronic ocular inflammation - CONTINUATION	
Fistulising Crohn's disease - INITIATION	
Fistulising Crohn's disease - CONTINUATION	
Fulminant ulcerative colitis - CONTINUATION	
Neurosarcoidosis - INITIATION	
Neurosarcoidosis - INTIATION	
Plague psoriasis - INITIATION	
Plaque psoriasis - CONTINUATION	
Psoriatic arthritis - INITIATION	
Psoriatic arthritis - CONTINUATION	
Pyoderma gangrenosum - INITIATION	
Pyoderma gangrenosum - CONTINUATION	
Rheumatoid arthritis - INITIATION	
Rheumatoid arthritis - CONTINUATION	
Severe Behcet's disease - INITIATION	
Severe Behcet's disease - CONTINUATION	
Severe ocular inflammation - INITIATION	
Severe ocular inflammation - CONTINUATION	
Ulcerative colitis - INITIATION	
Ulcerative colitis - CONTINUATION	328

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	e Pharmaceutical
Schedule. For community funding, see the Special Authority Criteria.			

PRES	CRIBER	PATIENT:			
Name	:	Name:			
Ward:	Ward: NHI:				
Inflix	imab				
	ATION – Graft vs host disease equisites (tick box where appropriate)				
(D Patient has steroid-refractory acute graft vs. host disease of the gu	t			
Re-a	ATION – rheumatoid arthritis ssessment required after 4 months equisites (tick boxes where appropriate)				
(and	Prescribed by, or recommended by a rheumatologist, or in accorda Hospital.	nce with a protocol or guideline that has been endorsed by the Health NZ			
	O The patient has had an initial Special Authority approval for a	dalimumab and/or etanercept for rheumatoid arthritis			
	O The patient has experienced intolerable side effects fro	m a reasonable trial of adalimumab and/or etanercept			
		/or etanercept, the patient did not meet the renewal criteria for			
	and Treatment is to be used as an adjunct to methotrexate therap intolerance	y or monotherapy where use of methotrexate is limited by toxicity or			
Prere (ssessment required after 6 months equisites (tick boxes where appropriate) O Prescribed by, or recommended by a rheumatologist, or in accorda Hospital.	nce with a protocol or guideline that has been endorsed by the Health NZ			
and	O Treatment is to be used as an adjunct to methotrexate therap intolerance	y or monotherapy where use of methotrexate is limited by toxicity or			
	O Following 3 to 4 months' initial treatment, the patient h clinically significant response to treatment in the opinion or	as at least a 50% decrease in active joint count from baseline and a n of the physician			
	\sim	provement in active joint count from baseline and a clinically significant			
	Infliximab to be administered at doses no greater than 3 mg/k	kg every 8 weeks			
Re-a	ATION – ankylosing spondylitis ssessment required after 3 months equisites (tick boxes where appropriate)				
(and	Prescribed by, or recommended by a rheumatologist, or in accordand Hospital.	nce with a protocol or guideline that has been endorsed by the Health NZ			
	O The patient has had an initial Special Authority approval for a and	dalimumab and/or etanercept for ankylosing spondylitis			
	O The patient has experienced intolerable side effects fro	m a reasonable trial of adalimumab and/or etanercept			
	\sim	reatment, the patient did not meet the renewal criteria for adalimumab			

Signed:	Date:
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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.

PRES	CRIBER		PATIENT:		
Name: Name:			Name:		
Ward	Ward: NHI:				
Inflix	imab -	continued			
Re-a	ssessmer equisites	DN – ankylosing spondylitis It required after 6 months (tick boxes where appropriate) cribed by, or recommended by a rheumatologist, or in accordan	ce with a protocol or guideline that has been endorsed by the Health NZ		
and	Hosp	Following 12 weeks of infliximab treatment, BASDAI has impro or by 50%, whichever is less	eved by 4 or more points from pre-infliximab baseline on a 10 point scale,		
	and	Physician considers that the patient has benefited from treatm Infliximab to be administered at doses no greater than 5 mg/kg			
Re-a	ssessmer equisites	ital.	ce with a protocol or guideline that has been endorsed by the Health NZ		
	and	O The patient has experienced intolerable side effects from	alimumab and/or etanercept and/or secukinumab for psoriatic arthritis in a reasonable trial of adalimumab and/or etanercept and/or secukinumab and/or etanercept and/or secukinumab, the patient did not meet the r secukinumab for psoriatic arthritis.		
Re-a	ssessmer equisites		ce with a protocol or guideline that has been endorsed by the Health NZ		
	or	clinically significant response to treatment in the opinion	rovement in active joint count from baseline and a clinically significant		
	and	Infliximab to be administered at doses no greater than 5 mg/kg	g every 8 weeks		

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:
Infliximab - continued	

INITIATION – severe ocular inflammation Re-assessment required after 4 months Prerequisites (tick boxes where appropriate) () The patient has had an initial Special Authority approval for adalimumab for severe ocular inflammation and The patient has experienced intolerable side effects from adalimumab or The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for severe ocular inflammation or ()Patient has severe, vision-threatening ocular inflammation requiring rapid control and () Treatment with high-dose steroids (intravenous methylprednisolone) followed by high dose oral steroids has proven ineffective at controlling symptoms or Patient developed new inflammatory symptoms while receiving high dose steroids or Patient is aged under 8 years and treatment with high dose oral steroids and other immunosuppressants has proven ineffective at controlling symptoms

CONTINUATION – severe ocular inflammation Re-assessment required after 12 months

Drereguieitee (tiek bevee where energiete)

Prerequisites	(tick boxes	where	appropriate)
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(C	The patient has had a good clinical response following 3 initial doses
or	C	Following each 12-month treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis
~~		Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema)
or C	C	Following each 12-month treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old

Note: A trial withdrawal should be considered after every 24 months of stability, unless the patient is deemed to have extremely high risk of irreversible vision loss if infliximab is withdrawn.

I confirm that the above details are correct:

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:
Infliximab - continued	
INITIATION – chronic ocular inflammation	

	and	С	The p	patient has had an initial Special Authority approval for adalimumab for chronic ocular inflammation
			Ο	The patient has experienced intolerable side effects from adalimumab
		or	0	The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for chronic ocular inflammation
or				
	and	C	Patie loss	nt has severe uveitis uncontrolled with treatment of steroids and other immunosuppressants with a severe risk of vision
			Ο	Patient is 18 years or older and treatment with at least two other immunomodulatory agents has proven ineffective
		or	Ο	Patient is under 18 years and treatment with methotrexate has proven ineffective or is not tolerated at therapeutic dose
		or	0	Patient is under 8 years and treatment with steroids or methotrexate has proven ineffective or is not tolerated at a therapeutic dose; or disease requires control to prevent irreversible vision loss prior to achieving a therapeutic dose of methotrexate
	\square	_		

~	0	The patient has had a good clinical response following 3 initial doses
or or	0	Following each 12-month treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema)
U	0	Following each 12-month treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old
		ithdrawal should be considered after every 24 months of stability, unless the patient is deemed to have extremely high risk of irreversible fliximab is withdrawn.
		Pulmonary sarcoidosis (tick boxes where appropriate)
	0	Patient has life-threatening pulmonary sarcoidosis that is refractory to other treatments
and	O	Treatment is to be prescribed by, or has been recommended by, a physician with expertise in the treatment of pulmonary sarcoidosis

Form RS2065 April 2025	HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST	Page 325			
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:				
Infliximab - continued INITIATION – Crohn's disease (adults) Re-assessment required after 6 months					
Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevand NZ Hospital. and O Patient has active Crohn's disease and	ant practitioner, or in accordance with a protocol or guideline that has been	endorsed by the Health			
O Patient has a CDAI score of great or O Patient has extensive small intest or O Patient has evidence of short gut or O	tter than or equal to 300, or HBI score of greater than or equal to 10 tine disease affecting more than 50 cm of the small intestine t syndrome or would be at risk of short gut syndrome with further bowel res stomy, and has intestinal inflammation	ection			
Patient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators and corticosteroids CONTINUATION – Crohn's disease (adults) Re-assessment required after 2 years					

\cup	Prescribed by, or recommended by any releva	ant practitioner,	or in accordance wi	th a protocol or guidelir	ne that has been end	dorsed by the Health
	NZ Hospital.					
and						

	Ο	,	00 points from the	CDAI score, or HBI score h	as reduced by 3 points, from when the patient was
		initiated on infliximab			
or	\sim				

O CDAI score is 150 or less, or HBI is 4 or less

O The patient has demonstrated an adequate response to treatment but CDAI score and/or HBI score cannot be assessed

O Infliximab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for up to 3 doses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen weeks after completing the last re-induction cycle

INITIATION – Crohn's disease (children)

or

and

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

Ć)	Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
		NZ Hospital.
and		

and		O Patient has a PCDAI score of greater than or equal to 30
	or	O Patient has extensive small intestine disease

Signed: Date:	
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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.

PRES	CRIBER		PATIENT:
Name	:		Name:
Ward:			NHI:
Inflix	imab -	continued	
Re-a	ssessmer equisites O Prese	DN – Crohn's disease (children) nt required after 2 years (tick boxes where appropriate) cribed by, or recommended by any relevant practitioner, or in ac lospital.	cordance with a protocol or guideline that has been endorsed by the Health
	or	O PCDAI score is 15 or less	
	and		weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for nent for re-induction. Another re-induction may be considered sixteen
	equisites	Dital. Patient has confirmed Crohn's disease O Patient has one or more complex externally draining ent O Patient has one or more rectovaginal fistula(e)	dance with a protocol or guideline that has been endorsed by the Health NZ erocutaneous fistula(e)
Re-a	ssessmer equisites O Prese	O The number of open draining fistulae have decreased fr	tula(e) from baseline (in the case of adult patients, as demonstrated by
	0		weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for nent for re-induction. Another re-induction may be considered sixteen

Use this checklist to determine if a patient meets the restrictions for funding in Schedule. For community funding, see the Special Authority Criteria.	n the hospital setting . For more details, refer to Section H of the Pharmaceutical				
PRESCRIBER	PATIENT:				
Name:	Name:				
Ward:	NHI:				
Infliximab - continued					
INITIATION – acute fulminant ulcerative colitis Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a gastroenterologist, or in acc Hospital.	cordance with a protocol or guideline that has been endorsed by the Health NZ				
O Patient has acute, fulminant ulcerative colitis and O Treatment with intravenous or high dose oral corticosteroid	s has not been successful				
CONTINUATION – fulminant ulcerative colitis Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)					
O Prescribed by, or recommended by any relevant practitioner, or in NZ Hospital.	accordance with a protocol or guideline that has been endorsed by the Health				
reassessed every 6 months and Infliximab to be administered at doses up to 5 mg/kg every	nfliximab should be used in combination with immunomodulators and 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for eatment for re-induction. Another re-induction may be considered sixteen				
INITIATION – ulcerative colitis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in NZ Hospital.	n accordance with a protocol or guideline that has been endorsed by the Health				
and Patient has active ulcerative colitis and O Patients SCCAI is greater than or equal to 4 or O Patients PUCAI score is greater than or equal to 20 and					
O Patient has experienced an inadequate response to, or into systemic corticosteroids	plerable side effects from, prior therapy with immunomodulators and				

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.

PRES	CRI	BER			PATIENT:
Name	:				Name:
Ward:					NHI:
Inflix	ima	ab -	contir	nued	
Re-a	sses equi:	sme sites Pres	nt requ (tick	uired a boxes I by, o	tive colitis after 2 years where appropriate) r recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
	and	or I O	O Inflix up to	The imab	SCCAI score has reduced by 2 points or more from the SCCAI score when the patient was initiated on infliximab PUCAI score has reduced by 30 points or more from the PUCAI score when the patient was initiated on infliximab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for ses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen ar completing the last re-induction cycle
Re-a	sses equis	sme sites	nt requ (tick cribec	uired a boxes	riasis after 3 doses where appropriate) r recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
	or	ar		psor O	Patient has not an initial Special Authority approval for adalimumab, etanercept or secukinumab for severe chronic plaque iasis Patient has experienced intolerable side effects from adalimumab, etanercept or secukinumab Patient has received insufficient benefit from adalimumab, etanercept or secukinumab to meet the renewal criteria for adalimumab, etanercept or secukinumab for severe chronic plaque psoriasis Patient has "whole body" severe chronic plaque psoriasis with a Psoriasis Area and Severity Index (PASI) score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis
			Ind Ind Ind Uate r	Patie of th A PA cour The	Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis Patient has severe chronic localised genital or flexural plaque psoriasis where the plaques or lesions have been present for at least 6 months from the time of initial diagnosis, and with a Dermatology Life Quality Index (DLQI) score greater than 10 ent has tried, but had an inadequate response (see Note) to, or has experienced intolerable side effects from, at least three e following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, cyclosporin, or acitretin ASI assessment has been completed for at least the most recent prior treatment course (but preferably all prior treatment ses), preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course most recent PASI assessment is no more than 1 month old at the time of initiation se" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 10, as assessed preferably no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the
face, seve	hano re, ar	d, foo nd fo	ot, ger r the f	nital or ace, p	flexural areas at least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very alm of a hand or sole of a foot, as assessed atment but no longer than 1 month following cessation of the most recent prior treatment.

I confirm that the above details are correct:

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:

Infliximab - continued

	O	Patient had "whole body" severe chronic plaque psoriasis at the start of treatment
	and	Following each prior infliximab treatment course the patient has a PASI score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-infliximab treatment baseline value
or		
	and	Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment
	0	 Following each prior infliximab treatment course the patient has a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the treatment course baseline values Following each prior infliximab treatment course the patient has a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-infliximab treatment baseline value
or	and	Patient had severe chronic localised genital or flexural plaque psoriasis at the start of treatment
	0	O The patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline value
		O Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing infliximab

Re-assessment required after 18 months
Prerequisites (tick boxes where appropriate)

Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
Hospital.

M
Biopsy consistent with diagnosis of neurosarcoidosis
and
Patient has CNS involvement
and
Patient has steroid-refractory disease
and

O IV cyclophosphamide has been tried

O Treatment with IV cyclophosphamide is clinically inappropriate

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:
Infliximab - continued	
CONTINUATION – neurosarcoidosis Re-assessment required after 18 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a neurologist, or in accordance Hospital. and or O A withdrawal period has been tried and the patient has relaps or O A withdrawal period has been considered but would not and O There has been a marked reduction in prednisone dose and O There has been an improvement in MRI appeara or O Marked improvement in other symptomology	t be clinically appropriate
INITIATION – severe Behcet's disease Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	y impacting the patient's quality of life (see Notes)
or or	and/or mucocutaneous symptoms and has not responded adequately to
and O The patient is experiencing significant loss of quality of life	
 Note: a) Behcet's disease diagnosed according to the International Study Group for measured using an appropriate quality of life scale such as that published b) Treatments appropriate for the particular symptoms are those that are corr intravenous/oral steroids and other immunosuppressants for ocular symptom mucocutaneous symptoms; and colchicine, steroids and methotrexate for 	d in Gilworth et al J Rheumatol. 2004;31:931-7. Insidered standard conventional treatments for these symptoms, for example toms; azathioprine, steroids, thalidomide, interferon alpha and ciclosporin for
CONTINUATION – severe Behcet's disease Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	vith measurably improved quality of life

O Infliximab to be administered at doses no greater than 5 mg/kg every 8 weeks

I confirm that the above details are correct:

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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:			
Infliximab - continued				
INITIATION – pyoderma gangrenosum Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a dermatologist, or in accordant Hospital. and	nce with a protocol or guideline that has been endorsed by the Health NZ			
 Patient has pyoderma gangrenosum* Patient has received three months of conventional therapy ir azathioprine, or methotrexate) and not received an adequate A maximum of 8 doses 	ncluding a minimum of three pharmaceuticals (e.g. prednisone, ciclosporin, e response			
Note: Indications marked with * are unapproved indications.				
CONTINUATION – pyoderma gangrenosum Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a dermatologist, or in accordan Hospital.	nce with a protocol or guideline that has been endorsed by the Health NZ			
 Patient has shown clinical improvement and Patient continues to require treatment and A maximum of 8 doses 				
INITIATION – Inflammatory bowel arthritis (axial) Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)				
 Patient has a diagnosis of active ulcerative colitis or active Crohn's disease Patient has had axial inflammatory pain for six months or more Patient is unable to take NSAIDs Patient has unequivocal sacrolliitis demonstrated by radiological imaging or MRI Patient has not experienced an adequate response to prior treatment consisting of at least 3 months of an exercise regime supervised by a physiotherapist Patient has a BASDAI of at least 6 on a 0-10 scale completed after the 3 month exercise trial, but prior to ceasing any previous pharmacological treatment 				
CONTINUATION – Inflammatory bowel arthritis (axial) Re-assessment required after 2 years Prerequisites (tick box where appropriate) O Where treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10-point scale, or an improvement in BASDAI of 50%, whichever is less				

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			R PATIENT:	
Name	:		Name:	
Ward			NHI:	
Inflix	kima	ıb - d	- continued	
Re-a	ssess	smen	- Inflammatory bowel arthritis (peripheral) ent required after 6 months s (tick boxes where appropriate)	
	and	0	Patient has a diagnosis of active ulcerative colitis or active Crohn's disease	
	and	Ο	Patient has active arthritis in at least four joints from the following: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder, sternoclavicular	
		0	Patient has tried and not experienced a response to at least three months of methotrexate or azathioprine at a maximum tolerated dose (unless contraindicated)	
	and	0	Patient has tried and not experienced a response to at least three months of sulfasalazine at a maximum tolerated dose (unless contraindicated)	
	and		O Patient has a CRP level greater than 15 mg/L measured no more than one month prior to the date of this application	
		or	Patient has an ESR greater than 25 mm per hour measured no more than one month prior to the date of this application	
		or	C ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months	
\subseteq		_		
Re-a	ssess	smen	CION – Inflammatory bowel arthritis (peripheral) ent required after 2 years s (tick boxes where appropriate)	
		0	Following initial treatment, patient has experienced at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician	
	or	0	Patient has experienced at least a continuing 30% improvement in active joint count from baseline in the opinion of the treating physician	
\square				

RS2067 - Tocilizumab

Rheumatoid Arthritis - INITIATION	
Rheumatoid Arthritis - CONTINUATION	
Rheumatoid Arthritis (patients previously treated with adalimumab or etanercept) - INITIATION	
Adult-onset Still's disease - INITIATION	
Adult-onset Still's disease - CONTINUATION	
Cytokine release syndrome - INITIATION	
Idiopathic multicentric Castleman's disease - INITIATION	
Idiopathic multicentric Castleman's disease - CONTINUATION	
Moderate to severe COVID-19 - INITIATION	
Polyarticular juvenile idiopathic arthritis - INITIATION	
Polyarticular juvenile idiopathic arthritis - CONTINUATION	
Previous use - INITIATION	
Systemic juvenile idiopathic arthritis - INITIATION	
Systemic juvenile idiopathic arthritis - CONTINUATION	

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:		

Tocilizumab

Re-a	ssess	ment rec	tine release syndrome uired after 3 doses boxes where appropriate)
	(and	The patient has developed grade 3 or 4 cytokine release syndrome associated with the administration of blinatumomab for the treatment of acute lymphoblastic leukaemia Tocilizumab is to be administered at doses no greater than 8 mg/kg IV for a maximum of 3 doses (if less than 30kg, maximum of 12 mg/kg)
	or	and and	The patient is enrolled in the Malaghan Institute of Medical Research ENABLE trial programme The patient has developed CRS or Immune Effector Cell-Associated Neurotoxicity Syndrome (ICANS) following CAR T-Cell therapy for the treatment of relapsed or refractory B-cell non-Hodgkin lymphoma Tocilizumab is to be administered according to the consensus guidelines for CRS or ICANS for CAR T-cell therapy at doses no greater than 8 mg/kg IV for a maximum of 3 doses
Re-a	ssess	ment rec	ous use uired after 6 months boxes where appropriate)
(and		Prescribe NZ Hospi	d by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health al.
	and	O Pat	ent was being treated with tocilizumab prior to 1 February 2019
		or C	Rheumatoid arthritis Systemic juvenile idiopathic arthritis
		or or	Adult-onset Still's disease
		or	Polyarticular juvenile idiopathic arthritis
			Idiopathic multicentric Castleman's disease

Use this checklist to determine if a patient meets the restrictions for funding in the hospital setting	J. For more details, refer to Section H of the Pharmaceutical
Schedule. For community funding, see the Special Authority Criteria.	

PRESCRIB	BER		PATIENT:				
Name:							
Ward:			NHI:				
Tocilizum	nab	- conti	nued				
			atoid Arthritis (patients previously treated with adalimumab or etanercept) ed after 6 months				
			xes where appropriate)				
			y, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a uideline that has been endorsed by the Health NZ Hospital.				
(and	0	The pa	tient has had an initial Special Authority approval for adalimumab and/or etanercept for rheumatoid arthritis				
	or	0 -	The patient has experienced intolerable side effects from adalimumab and/or etanercept				
	U		The patient has received insufficient benefit from at least a three-month trial of adalimumab and/or etanercept such that they do not meet the renewal criteria for rheumatoid arthritis				
and							
	O The patient is seronegative for both anti-cyclic citrullinated peptide (CCP) antibodies and rheumatoid factor						
O The patient has been started on rituximab for rheumatoid arthritis in a Health NZ Hospital and							
			O The patient has experienced intolerable side effects from rituximab				
			At four months following the initial course of rituximab the patient has received insufficient benefit such that they do not meet the renewal criteria for rheumatoid arthritis				

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.

PRE	SCRIB	ER		PATIENT:	
Name	ə:			Name:	
Ward	:			NHI:	
Тосі	lizun	nab	- coi	ntinued	
Re-a	assess requisi	men ites Preso	t requ (tick k cribed	matoid Arthritis irred after 6 months poxes where appropriate) by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.	
and	and (С С	citrul	ent has had severe and active erosive rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic linated peptide (CCP) antibody positive) for six months duration or longer izumab is to be used as monotherapy	
	anu	or	0 0	Treatment with methotrexate is contraindicated Patient has tried and did not tolerate oral and/or parenteral methotrexate	
	and	or	0 0	Patient has tried and not responded to at least three months therapy at the maximum tolerated dose of ciclosporin alone or in combination with another agent Patient has tried and not responded to at least three months therapy at the maximum tolerated dose of leflunomide alone or in combination with another agent	
	and	or	0 0	Patient has persistent symptoms of poorly controlled and active disease in at least 20 active, swollen, tender joints Patient has persistent symptoms of poorly controlled and active disease in at least four active joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip	
	and	or	0 0	Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application C-reactive protein levels not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months	
Re-a	assess requisi	men ites	t requ (tick b	mic juvenile idiopathic arthritis hired after 6 months boxes where appropriate) by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a	
and Patient diagnosed with systemic juvenile idiopathic arthritis and Patient diagnosed with systemic juvenile idiopathic arthritis Patient has tried and not responded to a reasonable trial of all of the following, either alone or in combination: oral or parenteral methotrexate; non-steroidal anti-inflammatory drugs (NSAIDs); and systemic corticosteroids					

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.

RESCRI	BER		PATIENT:
ame:			
/ard:			NHI:
ocilizu	mab	- con	tinued
Re-asses Prerequi	sment sites (Presc	requ tick b ribed	onset Still's disease red after 6 months oxes where appropriate) oy, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.
		or	O The patient has had an initial Special Authority approval for adalimumab and/or etanercept for adult-onset Still's disease (AOSD)
			O The patient has been started on tocilizumab for AOSD in a Health NZ Hospital
	and	or	O The patient has experienced intolerable side effects from adalimumab and/or etanercept
			O The patient has received insufficient benefit from at least a three-month trial of adalimumab and/or etanercept such that they do not meet the renewal criteria for AOSD
	and	0	Patient has persistent symptoms of disabling poorly controlled and active disease
e-asses rerequi	sment sites (tick b	ticular juvenile idiopathic arthritis red after 4 months oxes where appropriate) oy, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a
nd	protoc	ol or	guideline that has been endorsed by the Health NZ Hospital.
	and	0	The patient has had an initial Special Authority approval for both etanercept and adalimumab for polyarticular course juvenile idiopathic arthritis (JIA)
		0	The patient has experienced intolerable side effects, or has received insufficient benefit from, both etanercept and adalimumab
or		0	Treatment with a tumour necrosis factor alpha inhibitor is contraindicated
	and	0	Patient has had polyarticular course JIA for 6 months duration or longer
	and	0	To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance
		or	O At least 5 active joints and at least 3 joints with limited range of motion, pain or tenderness after a 3-month trial of methotrexate (at the maximum tolerated dose)
		or	O Moderate or high disease activity (cJADAS10 score of at least 2.5) after a 3-month trial of methotrexate (at the maximum tolerated dose)
			O Low disease activity (cJADAS10 score between 1.1 and 2.5) after a 6-month trial of methotrexate

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.

PRES	CRIBER	PATIENT:
Name		Name:
Ward:		NHI:
	izumab - continued	
	ATION – idiopathic multicentric Castleman's disease	
Re-a	equisites (tick boxes where appropriate)	
and	Prescribed by, or recommended by a haematologist, rheumatologis or in accordance with a protocol or guideline that has been endorse	st or Practitioner on the recommendation of a haematologist or rheumatologist, ed by the Health NZ Hospital.
	O Patient has severe HHV-8 negative idiopathic multicentric Ca	Istleman's disease
	O Treatment with an adequate trial of corticosteroids has proven and	n ineffective
	O Tocilizumab to be administered at doses no greater than 8 m	g/kg IV every 3-4 weeks
	ATION – moderate to severe COVID-19	
	ssessment required after 1 dose	
Prere	equisites (tick boxes where appropriate)	
	O Patient has confirmed (or probable) COVID-19	
	O Oxygen saturation of < 92% on room air, or requiring supplementation	nental oxygen
	O Patient is receiving adjunct systemic corticosteroids, or system	mic corticosteroids are contraindicated
	O Tocilizumab is to be administered at doses no greater than 8 and	mg/kg IV for a maximum of one dose
	O Tocilizumab is not to be administered in combination with bar	rcitinib
	TINUATION – Rheumatoid Arthritis ssessment required after 6 months	
	equisites (tick boxes where appropriate)	
(and	Prescribed by, or recommended by a rheumatologist or Practitioner protocol or guideline that has been endorsed by the Health NZ Hos	r on the recommendation of a rheumatologist, or in accordance with a spital.
	O Following 6 months' initial treatment, the patient has at least significant response to treatment in the opinion of the physician or	a 50% decrease in active joint count from baseline and a clinically an
	\sim	east a continuing 30% improvement in active joint count from baseline and the physician
	TINUATION – systemic juvenile idiopathic arthritis	
Re-a	equisites (tick boxes where appropriate)	
(and	Prescribed by, or recommended by a rheumatologist or Practitioner protocol or guideline that has been endorsed by the Health NZ Hos	r on the recommendation of a rheumatologist, or in accordance with a pital.
	improvement criteria (ACR Pedi 30) response from baseline	hieved at least an American College of Rheumatology paediatric 30%
	or O On subsequent reapplications, the patient demonstrates at le	east a continuing ACR Pedi 30 response from baseline

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 th	ne Pharmaceutical
Schedule. For community funding, see the Special Authority Criteria.			

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Tocilizumab - continued	
CONTINUATION – adult-onset Still's disease Re-assessment required after 6 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a rheumatologist or Practitioner protocol or guideline that has been endorsed by the Health NZ Hosp and O The patient has a sustained improvement in inflammatory markers a	
CONTINUATION – polyarticular juvenile idiopathic arthritis	
and protocol or guideline that has been endorsed by the Health NZ Hosp	on the recommendation of a rheumatologist, or in accordance with a pital. y or monotherapy where use of methotrexate is limited by toxicity or
or physician's global assessment from baseline	as at least a 50% decrease in active joint count and an improvement in s at least a continuing 30% improvement in active joint count and nt from baseline
CONTINUATION – idiopathic multicentric Castleman's disease Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a haematologist, rheumatologist or in accordance with a protocol or guideline that has been endorse and	t or Practitioner on the recommendation of a haematologist or rheumatologist, ed by the Health NZ Hospital.
The treatment remains appropriate and the patient has a sustained	improvement in inflammatory markers and functional status

I confirm that the above details are correct:

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:		
Omalizumab			
NITIATION – severe asthma			

s (tick boxes where appropriate) scribed by, or recommended by a clinical immunologist or respiratory specialist, or in accordance with a protocol or guideline that has been orsed by the Health NZ Hospital.		
Patient must be aged 6 years or older		
Patient has a diagnosis of severe asthma		
Past or current evidence of atopy, documented by skin prick testing or RAST		
Total serum human immunoglobulin E (IgE) between 76 IU/mL and 1300 IU/ml at baseline		
Proven adherence with optimal inhaled therapy including high dose inhaled corticosteroid (budesonide 1,600 mcg per day or fluticasone propionate 1,000 mcg per day or equivalent), plus long-acting beta-2 agonist therapy (at least salmeterol 50 mcg bd or eformoterol 12 mcg bd) for at least 12 months, unless contraindicated or not tolerated		
Patient has received courses of systemic corticosteroids equivalent to at least 28 days treatment in the past 12 months, 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 steroids		
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 26 weeks after the first dose to assess response to treatment		
CONTINUATION – severe asthma		

O Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

O An increase in the Asthma Control Test (ACT) score of at least 5 from baseline and

A reduction in the maintenance oral corticosteroid dose or number of exacerbations of at least 50% from baseline

 \bigcirc

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.

PRESCRI	BER	PATIE	NT:
Name:		Name	
Ward:			
Omalizu	ımab	• continued	
Re-asses Prerequis	sment i sites (t Prescri	severe chronic spontaneous urticaria It required after 6 months (tick boxes where appropriate) cribed by, or recommended by a clinical immunologist or dermatologist rsed by the Health NZ Hospital.	, or in accordance with a protocol or guideline that has been
and	O f	Patient must be aged 12 years or older	
		O Patient is symptomatic with Urticaria Activity Score 7 (UA and O Patient has a Dermatology life quality index (DLQI) of 10	
and O Patient has been taking high dose antihistamines (e.g. 4 times standard dose) and ciclosporin (> 3 mg/kg day)		s standard dose) and ciclosporin (> 3 mg/kg day) for at least	
	or or	(> 20 mg prednisone per day for at least 5 days) in the previou	
and	ٰ ا	O Patient has developed significant adverse effects whilst on cort	
	or	O Treatment to be stopped if inadequate response* following 4 do	oses
		O Complete response* to 6 doses of omalizumab	
Re-asses Prerequis	sment sites (t Prescri	DN – severe chronic spontaneous urticaria It required after 6 months (tick boxes where appropriate) cribed by, or recommended by a clinical immunologist or dermatologist	, or in accordance with a protocol or guideline that has been
	endors	rsed by the Health NZ Hospital. Patient has previously had a complete response* to 6 doses of omaliz	
	and	 Patient has previously had a complete response* to 6 doses of Patient has relapsed after cessation of omalizumab therapy 	omalizumab

Note: *Inadequate response defined as less than 50% reduction in baseline UAS7 and DLQI score, or an increase in Urticaria Control Test (UCT) score of less than 4 from baseline. Patient is to be reassessed for response after 4 doses of omalizumab. Complete response is defined as UAS7 less than or equal to 6 and DLQI less than or equal to 5; or UCT of 16. Relapse of chronic urticaria on stopping prednisone/ciclosporin does not justify the funding of omalizumab.

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:

Siltuximab

and

Re-a	FION essment required after 6 months uisites (tick boxes where appropriate)	
and	Prescribed by, or recommended by a haematologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed the Health NZ Hospital.	у
anu	 Patient has severe HHV-8 negative idiopathic multicentric Castleman's Disease Treatment with an adequate trial of corticosteroids has proven ineffective Siltuximab is to be administered at doses no greater than 11 mg/kg every 3 weeks 	
Re-a	NUATION essment required after 12 months uisites (tick box where appropriate) Prescribed by, or recommended by a haematologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by	

the Health NZ Hospital.

The treatment remains appropriate and the patient has sustained improvement in inflammatory markers and functional status

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:

Obinutuzumab

INITIATION Re-assessment required after 6 months			
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.			
 The patient has progressive Binet stage A, B or C CD20+ chronic lymphocytic leukaemia requiring treatment and The patient is obinutuzumab treatment naive and The patient is not eligible for full dose FCR due to comorbidities with a score > 6 on the Cumulative Illness Rating Scale (CIRS) or reduced renal function (creatinine clearance < 70mL/min) and Patient has adequate neutrophil and platelet counts* unless the cytopenias are a consequence of marrow infiltration by CLL and Patient has good performance status and Obinutuzumab to be administered at a maximum cumulative dose of 8,000 mg and in combination with chlorambucil for a maximum of 6 cycles Note: Chronic lymphocytic leukaemia includes small lymphocytic lymphoma. Comorbidity refers only to illness/impairment other than CLL induced illness/impairment in the patient. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL disease symptoms a higher ECOG (2 or 3) is acceptable where treatment with obinutuzumab is expected to improve symptoms and improve ECOG score to < 2. * greater than or equal to 1.5 × 10⁹/L and platelets greater than or equal to 75 × 10⁹/L 			
INITIATION – follicular / marginal zone lymphoma Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)			
or O Patient has follicular lymphoma O Patient has marginal zone lymphoma			
 and Patient is refractory to or has relapsed within 12 months of a rituximab containing combined chemo-immunotherapy regimen* Patient has an ECOG performance status of 0-2 and Patient has been previously treated with no more than four chemotherapy regimens and Obinutuzumab to be administered at a maximum dose of 1000 mg for a maximum of 6 cycles in combination with chemotherapy* 			
Note: * includes unapproved indications			
CONTINUATION – follicular / marginal zone lymphoma			

Re-assessment required after 24 months

Prerequisites (tick boxes where appropriate)

()Patient has no evidence of disease progression following obinutuzumab induction therapy and \bigcirc Obinutuzumab to be administered at a maximum of 1000 mg every 2 months for a maximum of 2 years and ${
m O}$ Obinutuzumab to be discontinued at disease progression

I confirm that the above details are correct:

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:
Deutereur ek	

Pertuzumab

INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)			
	O The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)		
		or	O Patient is chemotherapy treatment naive
			O Patient has not received prior treatment for their metastatic disease and has had a treatment free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer
	and and	0	The patient has good performance status (ECOG grade 0-1)
	and	Ο	Pertuzumab to be administered in combination with trastuzumab
	and	Ο	Pertuzumab maximum first dose of 840 mg, followed by maximum of 420 mg every 3 weeks
		0	Pertuzumab to be discontinued at disease progression
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)			
			O The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)
		an	10 The cancer has not progressed at any time point during the previous 12 months whilst on pertuzumab and trastuzumab
	or	an	O Patient has signs of disease progression
		an	Disease has not progressed during previous treatment with pertuzumab and trastuzumab

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:

Cetuximab

	head and neck cancer, locally advanced (tick boxes where appropriate)
	Patient has locally advanced, non-metastatic, squamous cell cancer of the head and neck
and	Cisplatin is contraindicated or has resulted in intolerable side effects
and	Patient has an ECOG performance score of 0-2
and	To be administered in combination with radiation therapy
Re-assessme	colorectal cancer, metastatic nt required after 6 months (tick boxes where appropriate)
Ο	Patient has metastatic colorectal cancer located on the left side of the colon (see Note)
and and	There is documentation confirming disease is RAS and BRAF wild-type

O Patient has an ECOG performance score of 0-2 and

O Patient has not received prior funded treatment with cetuximab and

O Cetuximab is to be used in combination with chemotherapy

 $\odot\,$ Chemotherapy is determined to not be in the best interest of the patient based on clinician assessment

CONTINUATION – colorectal cancer, metastatic Re-assessment required after 6 months Prerequisites (tick box where appropriate)

or

O No evidence of disease progression

Note: Left-sided colorectal cancer comprises of the distal one-third of the transverse colon, the splenic flexure, the descending colon, the sigmoid colon, or the rectum.

I confirm that the above details are correct:

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.

PRESCRI	BER		PATIEN	T:
Name:			Name:	
Ward:				
Afliberce	ept			
Re-assess Prerequis	sment sites (t Prescri	requi ick b bed	ge Related Macular Degeneration uired after 3 months poxes where appropriate) by, or recommended by an ophthalmologist or nurse practitioner, o by the Health NZ Hospital.	or in accordance with a protocol or guideline that has been
and		eub		
		or or	${ m O}~$ Polypoidal choroidal vasculopathy	vet AMD
	and	or	 O The patient has developed severe endophthalmitis or seven O There is worsening of vision or failure of retina to dry despirapart 	
	and and	о О	There is no structural damage to the central fovea of the treated of Patient has not previously been treated with ranibizumab for long	
or	or	С С	Patient has current approval to use ranibizumab for treatment of 3 months Patient has previously* (*before June 2018) received treatment w treatment	
Re-asses	sment	requi	Net Age Related Macular Degeneration uired after 12 months poxes where appropriate)	

endorsed by the Health NZ Hospital.

Documented	benefit	must k	be den	nonstrate	ed to	continue
Joounnenteu	bonioni	muor		nonotiati	54 10	continue

Patient's vision is 6/36 or better on the Snellen visual acuity score

There is no structural damage to the central fovea of the treated eye

I confirm that the above details are correct:

and

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and ()

and Ο 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:
Aflibercept - continued	
INITIATION – Diabetic Macular Oedema Re-assessment required after 4 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by an ophthalmologist or nurse praendorsed by the Health NZ Hospital. and	ctitioner, or in accordance with a protocol or guideline that has been
 Patient has centre involving diabetic macular oedema (DMO) and Patient's disease is non responsive to 4 doses of intravitreal to and Patient has reduced visual acuity between 6/9 – 6/36 with fundand Patient has DMO within central OCT (ocular coherence tomogrand There is no centre-involving sub-retinal fibrosis or foveal atrop 	ctional awareness of reduction in vision graphy) subfield > 350 micrometers
and endorsed by the Health NZ Hospital. There is stability or two lines of Snellen visual acuity gain and There is structural improvement on OCT scan (with reduction and Patient's vision is 6/36 or better on the Snellen visual acuity s and There is no centre-involving sub-retinal fibrosis or foveal atrop and	shy
After each consecutive 12 months treatment with aflibercept, no response	patient has retrialled with at least one injection of bevacizumab and had

I confirm that the above details are correct:

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.

PRES	SCRIE	BER	PATIENT:		
Name	e:		Name:		
Ward	:		NHI:		
Secu	ıkinı	uma	ıb		
			severe chronic plaque psoriasis, second-line biologic		
			t required after 4 months (tick boxes where appropriate)		
O Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health Hospital.					
	and	0	The patient has had an initial Special Authority approval for adalimumab or etanercept, or has trialled infliximab in a Health NZ Hospital, for severe chronic plaque psoriasis		
			O The patient has experienced intolerable side effects from adalimumab, etanercept or infliximab		
		or	O The patient has received insufficient benefit from adalimumab, etanercept or infliximab		
	and	0	A Psoriasis Area and Severity Index (PASI) assessment or Dermatology Quality of Life Index (DLQI) assessment has been completed for at least the most recent prior treatment course, preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course		
	and	0	The most recent PASI or DQLI assessment is no more than 1 month old at the time of application		
	TIA 11 1				
Re-a	ssess	smen	ON – severe chronic plaque psoriasis, second-line biologic t required after 6 months (tick boxes where appropriate)		
(and	F		bribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ		
		or	O Patient's PASI score has reduced by 75% or more (PASI 75) as compared to baseline PASI prior to commencing secukinumab		
				O Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing secukinumab	
	and	0	Secukinumab to be administered at a maximum dose of 300 mg monthly		

I confirm that the above details are correct:

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:
Secukinumab - continued	
INITIATION – severe chronic plaque psoriasis, first-line biologic Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a dermatologist, or in accordance Hospital.	e with a protocol or guideline that has been endorsed by the Health NZ
O Patient has "whole body" severe chronic plaque psorias 10, where lesions have been present for at least 6 mont	is with a Psoriasis Area and Severity Index (PASI) score of greater than the from the time of initial diagnosis
O Patient has severe chronic plaque psoriasis of the face, been present for at least 6 months from the time of initi	or palm of a hand or sole of a foot, where the plaque or plaques have al diagnosis
least 6 months from the time of initial diagnosis, and wit	laque psoriasis where the plaques or lesions have been present for at h a Dermatology Life Quality Index (DLQI) score greater than 10
and O Patient has tried, but had an inadequate response (see Note) following (at maximum tolerated doses unless contraindicated and	to, or has experienced intolerable side effects from, at least three of the): phototherapy, methotrexate, ciclosporin, or acitretin
	QI) assessment has been completed for at least the most recent prior iger than 1 month following cessation of each prior treatment course
O The most recent PASI or DQLI assessment is no more than 1	
Note: A treatment course is defined as a minimum of 12 weeks of treatment. psoriasis, a PASI score of greater than 10, as assessed preferably while still or recent prior treatment; for severe chronic plaque psoriasis of the face, hand, for erythema, thickness and scaling are rated as severe or very severe, and for more of the face, palm of a hand or sole of a foot, as assessed preferably white most recent prior treatment.	on treatment but no longer than 1 month following cessation of the most oot, genital or flexural areas, at least 2 of the 3 PASI symptom sub scores or the face, palm of a hand or sole of a foot the skin area affected is 30% or
CONTINUATION – severe chronic plaque psoriasis, first-line biologic Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O Patient's PASI score has reduced by 75% or more secukinumab	e (PASI 75) as compared to baseline PASI prior to commencing
to commencing secukinumab	DLQI) improvement of 5 or more, as compared to baseline DLQI prior
or O Patient had severe chronic localised genital or flex	kural plaque psoriasis at the start of treatment
and	75% or more in the skin area affected, or sustained at this level, as
\sim	dex (DLQI) improvement of 5 or more, as compared to baseline DLQI
and	
O Secukinumab to be administered at a maximum dose of 300 r	ng monthly

and

and

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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	PATIENT:
Name:	Name:
Ward:	NHI:
Secukinumab - continued	
INITIATION – ankylosing spondylitis, second-line biologic Re-assessment required after 3 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a rheumatologist, or in accordation Hospital.	ance with a protocol or guideline that has been endorsed by the Health NZ
and The patient has had an initial Special Authority approval for and	adalimumab and/or etanercept for ankylosing spondylitis
or	om a reasonable trial of adalimumab and/or etanercept treatment, the patient did not meet the renewal criteria for adalimumab
CONTINUATION – ankylosing spondylitis, second-line biologic Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a rheumatologist, or in accorda	ance with a protocol or guideline that has been endorsed by the Health NZ

C	Prescribed by, or recommended by a rheumatologist,	or in accordance w	vith a protocol or g	guideline that has been	endorsed by the Health NZ
	Hospital.				
and					

Ο	Following 12 weeks initial treatment of secukinumab treatment, BASDAI has improved by 4 or more points from pre-secukinumab
	baseline on a 10 point scale, or by 50%, whichever is less

Physician considers that the patient has benefitted from treatment and that continued treatment is appropriate

Secukinumab to be administered at doses no greater than 150 mg monthly

I confirm that the above details are correct:

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.

ab - c psoria	ontinu	ied	Name:
ab - c psoria	ontinu		NHI:
psoria		led	
	tic art		
	ired af oxes v	fter 6 months where appropriate)	ce with a protocol or guideline that has been endorsed by the Health NZ
O nd or	Patie	Patient has experienced intolerable side effects fro Patient has received insufficient benefit from adalir	om adalimumab, etanercept or infliximab numab, etanercept or infliximab to meet the renewal criteria for
	Patie week Patie	ent has tried and not responded to at least three more kly or a maximum tolerated dose ent has tried and not responded to at least three more	nths of oral or parenteral methotrexate at a dose of at least 20 mg
or	0 0		ed and active disease in at least 15 swollen, tender joints ed and active disease in at least four joints from the following: wrist,
nd or or	0 0 0	application Patient has an elevated erythrocyte sedimentation	15 mg/L measured no more than one month prior to the date of this rate (ESR) greater than 25 mm per hour y receiving prednisone therapy at a dose of greater than 5 mg per day
	or or or or or or or or	or O Patiend O P	 Patient has had an initial Special Authority approval for a of Patient has experienced intolerable side effects from Patient has received insufficient benefit from adaliant adalimumab, etanercept or infliximab for psoriatic at adalimumab, etanercept or infliximab for psoriatic at adalimumab, etanercept or a fillixing for psoriatic at three more adales of up to 20 mg daily (or maximum tolerated dose Patient has tried and not responded to at least three more adose of up to 20 mg daily (or maximum tolerated dose Patient has persistent symptoms of poorly controlle elbow, knee, ankle, and either shoulder or hip Patient has a C-reactive protein level greater than application Patient has an elevated erythrocyte sedimentation ESR and CRP not measured as patient is currently

and		Hos		by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
		OI	0	Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician
			0	The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior secukinumab treatment in the opinion of the treating physician
	and	d O	Secu	kinumab to be administered at doses no greater than 300 mg monthly

I confirm that the above details are correct:

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:

Trastuzumab emtansine

INITIATION – early breast cancer Prerequisites (tick boxes where appropriate) ()Patient has early breast cancer expressing HER2 IHC3+ or ISH+ and Documentation of pathological invasive residual disease in the breast and/or axiliary lymph nodes following completion of surgery and Patient has completed systemic neoadjuvant therapy with trastuzumab and chemotherapy prior to surgery and Disease has not progressed during neoadjuvant therapy and ()Patient has left ventricular ejection fraction of 45% or greater and () Adjuvant treatment with trastuzumab emtansine to be commenced within 12 weeks of surgery and \bigcirc Trastuzumab emtansine to be discontinued at disease progression and Total adjuvant treatment duration must not exceed 42 weeks (14 cycles)

INITIATION – metastatic breast cancer Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

and	Ο	Patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)		
and	Ο	Patient has previously received trastuzumab and chemotherapy, separately or in combination		
		O The patient has received prior therapy for metastatic disease*		
	or	O The patient developed disease recurrence during, or within six months of completing adjuvant therapy*		
and and	O Patient has a good performance status (ECOG 0-1)			
		O Patient does not have symptomatic brain metastases		
	or	or O Patient has brain metastases and has received prior local CNS therapy		
and				
	O Patient has not received prior funded trastuzumab emtansine or trastuzumab deruxtecan treatment or			
		O Patient has discontinued trastuzumab deruxtecan due to intolerance		
		The cancer did not progress while on trastuzumab deruxtecan		
and	0	Treatment to be discontinued at disease progression		

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:		
Trastuzumab emtansine - continued			
CONTINUATION – metastatic breast cancer Re-assessment required after 6 months			
Prerequisites (tick boxes where appropriate)			
O The cancer has not progressed at any time point during the previous approval period whilst on trastuzumab emtansine and			
O Treatment to be discontinued at disease progression			
Note: *Note: Prior or adjuvant therapy includes anthracycline, other chemotherapy, biological drugs, or endocrine therapy.			

I confirm that the above details are correct:

RS1973 - Rituximab

ABO-incompatible organ transplant - INITIATION	262
ANCA associated vasculitis - INITIATION	
ANCA associated vasculitis - CONTINUATION	
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CD20+ low grade or follicular B-cell NHL - CONTINUATION	368
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Chronic lymphocytic leukaemia - CONTINUATION	
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Neuromyelitis Optica Spectrum Disorder (NMOSD) - CONTINUATION	364
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Severe Refractory Myasthenia Gravis - CONTINUATION	365
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Severe antisynthetase syndrome - CONTINUATION	366
Steroid dependent nephrotic syndrome (SDNS) or frequently relapsing nephrotic syndrome (FRNS) - INITI	ATION
363	
Steroid dependent nephrotic syndrome (SDNS) or frequently relapsing nephrotic syndrome (FRNS) - CONTI	NUATIO
363	
Steroid resistant nephrotic syndrome (SRNS) - INITIATION	363
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Immunoglobulin G4-related disease (IgG4-RD*) - CONTINUATION	370
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Indolent, low-grade lymphomas or hairy cell leukaemia* - CONTINUATION	356
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Post-transplant - CONTINUATION	355
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Pure red cell aplasia (PRCA) - CONTINUATION	361
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Severe chronic inflammatory demyelinating polyneuropathy - CONTINUATION	366
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Severe cold haemagglutinin disease (CHAD) - CONTINUATION Thrombotic thrombocytopenic purpura (TTP) - INITIATION	358
Thrombotic thrombocytopenic purpura (TTP) - CONTINUATION	360
Treatment refractory systemic lupus erythematosus (SLE) - INITIATION	362
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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:		
Rituximab (Riximyo)		
INITIATION – haemophilia with inhibitors Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a haematologist, or in accordance Hospital. and O Patient has mild congenital haemophilia complicated by inhibit or O Patient has severe congenital haemophilia complicated by inhibit or O Patient has acquired haemophilia CONTINUATION – haemophilia with inhibitors Prerequisites (tick boxes where appropriate)	ibitors and has failed immune tolerance therapy be with a protocol or guideline that has been endorsed by the Health NZ with inhibitors	
INITIATION – post-transplant Prerequisites (tick boxes where appropriate) O The patient has B-cell post-transplant lymphoproliferative disorder*		
O To be used for a maximum of 8 treatment cycles Note: Indications marked with * are unapproved indications.		
CONTINUATION – post-transplant Prerequisites (tick boxes where appropriate)		
 The patient has had a rituximab treatment-free interval of 12 mand The patient has B-cell post-transplant lymphoproliferative diso and To be used for no more than 6 treatment cycles Note: Indications marked with * are unapproved indications. 		

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.

PRES	CRIBER	PATIENT:	PATIENT:		
Name:		Name:	Name:		
Ward:		NHI:			
Ritux	imab (Riximyo) - continued				
INITIATION – indolent, low-grade lymphomas or hairy cell leukaemia* Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)					
	and	O The patient has indolent low grade NHL or hairy cell leukaemia* with relapsed disease following prior chemotherapy and O To be used for a maximum of 6 treatment cycles			
or O The patient has indolent, low grade lymphoma or hairy cell leukaemia* requiring first-line systemic chemothe and O To be used for a maximum of 6 treatment cycles					
	'Indolent, low-grade lymphomas' includes fo tion. 'Hairy cell leukaemia' also includes hai	ollicular, mantle, marginal zone and lymphoplasmacytic/Waldenstrom macroglobulinaemia. * ry cell leukaemia variant.	Unapproved		
CONTINUATION – indolent, low-grade lymphomas or hairy cell leukaemia* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)					
 The patient has had a rituximab treatment-free interval of 12 months or more and The patient has indolent, low-grade NHL or hairy cell leukaemia* with relapsed disease following prior chemotherapy and 					
	O To be used for no more than 6 trea	atment cycles			
	'Indolent, low-grade lymphomas' includes fo tion. 'Hairy cell leukaemia' also includes hai	ollicular, mantle, marginal zone and lymphoplasmacytic/Waldenstrom macroglobulinaemia. * ry cell leukaemia variant.	Unapproved		
INITIATION – aggressive CD20 positive NHL Prerequisites (tick boxes where appropriate)					
	and	aive aggressive CD20 positive NHL nt chemotherapy regimen given with curative intent of 8 treatment cycles			
	or	CD20 positive NHL with relapsed disease following prior chemotherapy			
)		

Note: 'Aggressive CD20 positive NHL' includes large B-cell lymphoma and Burkitt's lymphoma/leukaemia.

I confirm that the above details are correct:

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:				
Ward:				
Rituxima	1 b (F	Riximyo) - <i>continued</i>		
	CONTINUATION – aggressive CD20 positive NHL Prerequisites (tick boxes where appropriate)			
and	\sim			
and	0	The patient has relapsed refractory/aggressive CD20 positive NHL To be used with a multi-agent chemotherapy regimen given with curative intent		
and	0	To be used for a maximum of 4 treatment cycles		
Note: 'Agg	gress	sive CD20 positive NHL' includes large B-cell lymphoma and Burkitt's lymphoma/leukaemia.		
Re-assess	men	Chronic lymphocytic leukaemia It required after 12 months (tick boxes where appropriate)		
and		The patient has progressive Binet stage A, B or C chronic lymphocytic leukaemia (CLL) requiring treatment		
	or	O The patient is rituximab treatment naive		
	O The patient is chemotherapy treatment naive			
		O The patient's disease has relapsed following no more than three prior lines of chemotherapy treatment		
		O The patient has had a treatment-free interval of 12 months or more if previously treated with fludarabine and cyclophosphamide chemotherapy		
	or	O The patient's disease has relapsed within 36 months of previous treatment and rituximab treatment is to be used in combination with funded venetoclax		
and and	O The patient has good performance status			
O The patient does not have chromosome 17p deletion CLL or O Rituximab treatment is to be used in combination with funded venetoclax for relapsed/refractory chronic lymphocytic leuka		O The patient does not have chromosome 17p deletion CLL		
		and	O Rituximab to be administered in combination with fludarabine and cyclophosphamide, bendamustine or venetoclax for a maximum of 6 treatment cycles	
	O It is planned that the patient receives full dose fludarabine and cyclophosphamide (orally or dose equivalent intravenous administration), bendamustine or venetoclax			
Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma. A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL disease symptoms a higher ECOG (2 or 3) is acceptable where treatment with rituximab is expected to improve symptoms and improve ECOG score to < 2.				

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.

PRESCRIE	BER PATIENT:
Name:	Name:
Ward:	NHI:
Rituxima	ab (Riximyo) - continued
CONTINU	IATION – Chronic lymphocytic leukaemia
	sment required after 12 months sites (tick boxes where appropriate)
	O The patient's disease has relapsed within 36 months of previous treatment and rituximab treatment is to be used in combination with funded venetoclax
	O The patient's disease has relapsed following no more than one prior line of treatment with rituximab for CLL and
	O The patient has had an interval of 36 months or more since commencement of initial rituximab treatment and
	O The patient does not have chromosome 17p deletion CLL and
	O It is planned that the patient receives full dose fludarabine and cyclophosphamide (orally or dose equivalent intravenous administration) or bendamustin
	O Rituximab to be administered in combination with fludarabine and cyclophosphamide, bendamustine or venetoclax for a maximum of 6 treatment cycles ronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma. A line of chemotherapy treatment is considered to comprise a known herapeutic chemotherapy regimen and supportive treatments.
Re-assess Prerequis	N – severe cold haemagglutinin disease (CHAD) sment required after 8 weeks sites (tick boxes where appropriate) 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 cold haemagglutinin disease*
and	O Patient has severe disease which is characterized by symptomatic anaemia, transfusion dependence or disabling circulatory symptoms
and	m O The total rituximab dose used would not exceed the equivalent of 375 mg/m2 of body surface area per week for a total of 4 weeks
Note: Indi	cations marked with * are unapproved indications.
Re-assess	ATION – severe cold haemagglutinin disease (CHAD) sment required after 8 weeks sites (tick boxes where appropriate)
	Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
or	O Previous treatment with lower doses of rituximab (100 mg weekly for 4 weeks) have proven ineffective and treatment with higher doses (375 mg/m ² weekly for 4 weeks) is now planned
	O Patient was previously treated with rituximab for severe cold haemagglutinin disease* and
	O An initial response lasting at least 12 months was demonstrated

Note: Indications marked with * are unapproved indications.

Patient now requires repeat treatment

and

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:		
Rituximab (Riximyo) - continued			
INITIATION – warm autoimmune haemolytic anaemia (warm AIHA) Re-assessment required after 8 weeks 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.			
Patient has warm autoimmune haemolytic anaemia* and One of the following treatments has been ineffective: steroids (including if patient requires ongoing steroids at doses equivalent to > 5 mg prednisone daily), cytotoxic agents (e.g. cyclophosphamide monotherapy or in combination), intravenous immunoglobulin and			
	ent of 375 mg/m2 of body surface area per week for a total of 4 weeks		
Note: Indications marked with * are unapproved indications.			
CONTINUATION – warm autoimmune haemolytic anaemia (warm AIHA) Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate)			
O Prescribed by, or recommended by a haematologist, or in accorda Hospital.	nce with a protocol or guideline that has been endorsed by the Health NZ		
Previous treatment with lower doses of rituximab (100 mg weekly for 4 weeks) have proven ineffective and treatment with higher doses (375 mg/m ² weekly for 4 weeks) is now planned or			
O Patient was previously treated with rituximab for warm	autoimmune haemolytic anaemia*		
An initial response lasting at least 12 months was demonstrated and			
O Patient now requires repeat treatment			
Note: Indications marked with * are unapproved indications.			
INITIATION – immune thrombocytopenic purpura (ITP) Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate)			
\sim	nce with a protocol or guideline that has been endorsed by the Health NZ		
O Patient has immune thrombocytopenic purpura* with a	a platelet count of less than or equal to 20,000 platelets per microlitre		
mucocutaneous bleeding	a platelet count of 20,000 to 30,000 platelets per microlitre and significant		
and O Treatment with steroids and splenectomy have been in	peffective		
or			
or			
	tive and patient is being prepared for elective surgery (e.g. splenectomy)		
And O The total rituximab dose used would not exceed the equivalent of 375 mg/m2 of body surface area per week for a total of 4 weeks			
Note: Indications marked with * are unapproved indications.)		

I confirm that the above details are correct:

Signed:		Date:	
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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:			
Rituximab (Riximyo) - continued				
CONTINUATION – immune thrombocytopenic purpura (ITP) Re-assessment required after 8 weeks 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.				
O Previous treatment with lower doses of rituximab (100 mg werdoses (375 mg/m ² weekly for 4 weeks) is now planned or	Previous treatment with lower doses of rituximab (100 mg weekly for 4 weeks) have proven ineffective and treatment with higher doses (375 mg/m ² weekly for 4 weeks) is now planned			
Patient was previously treated with rituximab for immur				
An initial response lasting at least 12 months was dem and O Patient now requires repeat treatment	onstrated			
Note: Indications marked with * are unapproved indications.				
Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a haematologist, or in accordan Hospital. and	nce with a protocol or guideline that has been endorsed by the Health NZ			
The total rituximab dose used would not exceed the equivale	nt of 375 mg/m2 of body surface area per week for a total of 4 weeks			
O Patient has thrombotic thrombocytopenic purpura* and thrombocytopenia despite plasma exchange	has experienced progression of clinical symptoms or persistent			
	nic purpura* with neurological or cardiovascular pathology			
Note: Indications marked with * are unapproved indications.				
CONTINUATION – thrombotic thrombocytopenic purpura (TTP) Re-assessment required after 8 weeks 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.				
 Patient was previously treated with rituximab for thrombotic that An initial response lasting at least 12 months was demonstrative 				
And Patient now requires repeat treatment				
The total rituximab dose used would not exceed the equivale	nt of 375 mg/m2 of body surface area per week for a total of 4 weeks			
Note: Indications marked with * are unapproved indications.				

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	ecklist to determine if a patient meets the restrict for community funding, see the Special Authorit	tions for funding in the hospital setting . For more details, refer ty Criteria.	to Section H of the Pharmaceutical
PRESCRIE	ER	PATIENT:	
Name:		Name:	
Ward:		NHI:	
Rituxima	b (Riximyo) - <i>continued</i>		
	N – pure red cell aplasia (PRCA) ment required after 6 weeks		
	ites (tick box where appropriate)		
and F	lospital.	gist, or in accordance with a protocol or guideline that has been ssociated with a demonstrable B-cell lymphoproliferative disorc	
Re-assess Prerequis	lospital.	gist, or in accordance with a protocol or guideline that has been pure red cell aplasia* associated with a demonstrable B-cell lyn 12 months ns.	
Re-assess		ssociated vasculitis* I the equivalent of 375 mg/m ² of body-surface area per week fo pulse intravenous cyclophosphamide has failed to achieve signi	
	or disease after at least 3 months Patient has previously had a cumula cyclophosphamide would result in a O Cyclophosphamide and methotrexat or O Patient is a female of child-bearing p	e are contraindicated	onth induction course of
	or		

O Patient has a previous history of haemorrhagic cystitis, urological malignancy or haematological malignancy

Note: Indications marked with * are unapproved indications.

CONTINUATION – ANCA associated vasculitis Re-assessment required after 8 weeks

Prerequisites (tick boxes where appropriate) O Patient has been diagnosed with ANCA associated vasculitis* and O Patient has previously responded to treatment with rituximab but is now experiencing an acute flare of vasculitis and O The total rituximab dose would not exceed the equivalent of 375 mg/m² of body-surface area per week for a total of 4 weeks Note: Indications marked with * are unapproved indications.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Rituximab (Riximyo) - continued	
INITIATION – treatment refractory systemic lupus erythematosus (SLE) Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a rheumatologist or nephrologist the Health NZ Hospital. and O The patient has severe, immediately life- or organ-threatening and O The disease has proved refractory to treatment with steroids a and O The disease has relapsed following prior treatment for at least	at a dose of at least 1 mg/kg 6 months with maximal tolerated doses of azathioprine, mycophenolate
Maximum of four 1000 mg infusions of rituximab Note: Indications marked with * are unapproved indications.	
CONTINUATION – treatment refractory systemic lupus erythematosus (S Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a rheumatologist or nephrologist the Health NZ Hospital.	SLE)
O Patient's SLE* achieved at least a partial response to the prev and O The disease has subsequently relapsed and O Maximum of two 1000 mg infusions of rituximab Note: Indications marked with * are unapproved indications.	rious round of prior rituximab treatment
INITIATION – Antibody-mediated organ transplant rejection Prerequisites (tick box where appropriate) O Patient has been diagnosed with antibody-mediated organ transplant Note: Indications marked with * are unapproved indications.	nt rejection*
INITIATION – ABO-incompatible organ transplant Prerequisites (tick box where appropriate) O Patient is to undergo an ABO-incompatible solid organ transplant* Note: Indications marked with * are unapproved indications.	

Use this checklist to determine if a patient meets the restrictions for funding i Schedule. For community funding, see the Special Authority Criteria.	n the hospital setting . For more details, refer to Section H of the Pharmaceutical
PRESCRIBER	PATIENT:
Name:	Name:
Ward: NHI:	
Rituximab (Riximyo) - continued	
Hospital.	ently relapsing nephrotic syndrome (FRNS) nce with a protocol or guideline that has been endorsed by the Health NZ
and O Patient is a child with SDNS* or FRNS* and O Treatment with steroids for at least a period of 3 months ha	as been ineffective or associated with evidence of steroid toxicity
O Treatment with ciclosporin for at least a period of 3 months and O Treatment with mycophenolate for at least a period of 3 mo and	has been ineffective and/or discontinued due to unacceptable side effects onths with no reduction in disease relapses elent of 375 mg/m ² of body surface area per week for a total of 4 weeks
Note: Indications marked with a * are unapproved indications.	
CONTINUATION – Steroid dependent nephrotic syndrome (SDNS) or f Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a nephrologist, or in accordan Hospital.	frequently relapsing nephrotic syndrome (FRNS)
Patient who was previously treated with rituximab for nephr and	rotic syndrome*
\sim	is demonstrated sustained response for > 6 months, but the condition has
	llent of 375 mg/m ² of body surface area per week for a total of 4 weeks
Note: Indications marked with a * are unapproved indications.	
Hospital.	nce with a protocol or guideline that has been endorsed by the Health NZ
and Treatment with tacrolimus for at least 3 months has been in and	
O Genetic causes of nephrotic syndrome have been excluded and O The total rituximab dose used would not exceed the equiva Note: Indications marked with a * are unapproved indications.	d llent of 375 mg/m ² of body surface area per week for a total of 4 weeks

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.

PRES	SCRIBE	ER PATIE	NT:
Name: Name:			
Ward: NHI:			
Ritu	ximab	D (Riximyo) - <i>continued</i>	
Re-a	issessme	TION – Steroid resistant nephrotic syndrome (SRNS) nent required after 8 weeks tes (tick boxes where appropriate)	
and		rescribed by, or recommended by a nephrologist, or in accordance with a pospital.	rotocol or guideline that has been endorsed by the Health NZ
	and	O Patient who was previously treated with rituximab for nephrotic syndro	me*
	and	Treatment with rituximab was previously successful and has demonstr condition has relapsed and the patient now requires repeat treatment	
		J The total rituximab dose used would not exceed the equivalent of 375	mg/m ² of body surface area per week for a total of 4 weeks
Note	: Indicat	ations marked with a * are unapproved indications.	
		nent required after 6 months tes (tick boxes where appropriate) One of the following dose regimens is to be used: 2 doses of 1,000 me weekly for four weeks	g rituximab administered fortnightly, or 4 doses of 375 mg/m2 administered
	o	O The patient has experienced a severe episode or attack of NMC supportive of a severe attack of NMOSD)	SD (rapidly progressing symptoms and clinical investigations
		The patient has experienced a breakthrough attack of NM and The patient is receiving treatment with mycophenolate	DSD
		and O The patients is receiving treatment with corticosteroids	
Re-a	issessme	TION – Neuromyelitis Optica Spectrum Disorder (NMOSD) nent required after 2 years tes (tick boxes where appropriate)	
	O	One of the following dose regimens is to be used: 2 doses of 1,000 m weekly for four weeks	g rituximab administered fortnightly, or 4 doses of 375 mg/m2 administered
	and O The patients has responded to the most recent course of rituximab and		
	O The patient has not received rituximab in the previous 6 months		

I confirm that the above details are correct:

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.

PRESCRI	BER	PATIENT:
Name: Name:		Name:
Ward:		NHI:
Rituxima	ab (R	iximyo) - continued
INITIATIC Re-asses Prerequis	DN – S ssmen sites Presc Hosp	Severe Refractory Myasthenia Gravis t required after 2 years (tick boxes where appropriate) ribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
		O Corticosteroids have been trialed for at least 12 months and have been discontinued due to unacceptable side effects
		N – Severe Refractory Myasthenia Gravis
Re-asses Prerequis	sites Presc Hosp	t required after 2 years (tick boxes where appropriate) ribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
		O The patient's myasthenia gravis has relapsed despite treatment with at least one immunosuppressant for a period of at least 12 months and O Corticosteroids have been trialed for at least 12 months and have been discontinued due to unacceptable side effects
Re-asses	smen	Severe antisynthetase syndrome t required after 12 months (tick boxes where appropriate)
and	0	Patient has confirmed antisynthetase syndrome Patient has severe, immediately life or organ threatening disease, including interstitial lung disease
	or	 O Treatment with at least 3 immunosuppressants (oral steroids, cyclophosphamide, methotrexate, mycophenolate, ciclosporin, azathioprine) has not be effective at controlling active disease O Panid treatment is required due to life threatening complications
and	U O	O Rapid treatment is required due to life threatening complications Maximum of four 1,000 mg infusions of rituximab

Form RS1 April 2025		MEDICINES LIST ONS CHECKLIST	Page 3
	klist to determine if a patient meets the restrictions for funding i community funding, see the Special Authority Criteria.	in the hospital setting . For more details, refer to Section H of the Pha	armaceutical
PRESCRIBE	8	PATIENT:	
Name:		Name:	
Ward:		NHI:	
Rituximab	(Riximyo) - continued		
Re-assessm	ION – Severe antisynthetase syndrome ent required after 12 months is (tick boxes where appropriate)		
and	Patient's disease has responded to the previous rituximab strength and pulmonary function	treatment with demonstrated improvement in inflammatory markers, n	nuscle
and	The patient has not received rituximab in the previous 6 mo		
	Maximum of two cycles of 2 × 1,000 mg infusions of rituxin	nab given two weeks apart]
	- graft versus host disease s (tick boxes where appropriate)		
and	Patient has refractory graft versus host disease following tr	ransplant	
and	Treatment with at least 3 immunosuppressants (oral steroid controlling active disease	ds, ciclosporin, tacrolimus, mycophenolate, sirolimus) has not be effect	ctive at
C	The total rituximab dose used would not exceed the equiva	alent of 375 mg/m ² of body surface area per week for a total of 4 week	ks
Re-assessm	 severe chronic inflammatory demyelinating polyneuropation ent required after 6 months s (tick boxes where appropriate) 	athy	
	escribed by, or recommended by a neurologist, or in accordancespital.	ce with a protocol or guideline that has been endorsed by the Health N	NZ
and	Patient has severe chronic inflammatory demyelinating pol	yneuropathy (CIPD)	
	active disease	noglobulin and/or plasma exchange has not been effective at controllin	ing
	At least one other immunosuppressant (cyclop effective at controlling active disease	hosphamide, ciclosporin, tacrolimus, mycophenolate) has not been	
	O Rapid treatment is required due to life threatening co	mplications	
and	One of the following dose regimens is to be used: 375 mg, weekly for four weeks, or two 1,000 mg doses given two weekly for four weeks, or two 1,000 mg doses given two weekly for four weeks, or two 1,000 mg doses given two weekly for four weeks, or two 1,000 mg doses given two weekly for four weeks, or two 1,000 mg doses given two weekly for four weeks, or two 1,000 mg doses given two weekly for four weeks, or two 1,000 mg doses given two weekly for four weeks, or two 1,000 mg doses given two weekly for four weeks, or two 1,000 mg doses given two weekly for four weeks, or two 1,000 mg doses given two weekly for four weeks, or two 1,000 mg doses given two weekly for four weeks, or two 1,000 mg doses given two weekly for four	/m2 of body surface area per week for a total of four weeks, or 500 mg eeks apart	g once
Re-assessm	ION – severe chronic inflammatory demyelinating polyne ent required after 6 months s (tick boxes where appropriate)	uropathy	
C	Patient's disease has responded to the previous rituximab compared to baseline	treatment with demonstrated improvement in neurological function	
and C and	O The patient has not received rituximab in the previous 6 months		
	One of the following dose regimens is to be used: 375 mg	/m2 of body surface area per week for a total of four weeks, or 500 m	a once

One of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg once weekly for four weeks, or two 1,000 mg doses given two weeks apart

I confirm that the above details are correct:

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:		
Rituximab (Riximyo) - continued			
INITIATION – anti-NMDA recentor autoimmune encenhalitis			

Re-assessment required after 6 months		
0	tes (tick boxes where appropriate) rescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ lospital.	
and	O Patient has severe anti-NMDA receptor autoimmune encephalitis	
	O Treatment with steroids and intravenous immunoglobulin and/or plasma exchange has not been effective at controlling active disease and O At least one other immunosuppressant (cyclophosphamide, ciclosporin, tacrolimus, mycophenolate) has not been effective at controlling active disease	
	or O Rapid treatment is required due to life threatening complications	
and	One of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg once weekly for four weeks, or two 1,000 mg doses given two weeks apart	
Re-asses Prerequi	ATION – anti-NMDA receptor autoimmune encephalitis ment required after 6 months tes (tick boxes where appropriate) rescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ lospital.	
and	 Patient's disease has responded to the previous rituximab treatment with demonstrated improvement in neurological function The patient has not received rituximab in the previous 6 months 	
and	The patient has experienced a relapse and now requires further treatment	
and	One of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg once weekly for four weeks, or two 1,000 mg doses given two weeks apart	
Re-asses	N – CD20+ low grade or follicular B-cell NHL ment required after 9 months tes (tick boxes where appropriate)	
	O The patient has CD20+ low grade or follicular B-cell NHL with relapsed disease following prior chemotherapy and O To be used for a maximum of 6 treatment cycles	
or	O The patient has CD20+ low grade or follicular B-cell NHL requiring first-line systemic chemotherapy and O To be used for a maximum of 6 treatment cycles	

Form RS1973	HOSPITAL MEDICINES LIST Page 3
April 2025	RESTRICTIONS CHECKLIST
Use this checklist to determine if a patient meets the re Schedule. For community funding, see the Special Au	estrictions for funding in the hospital setting . For more details, refer to Section H of the Pharmaceutical thority Criteria.
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Rituximab (Riximyo) - continued	
CONTINUATION – CD20+ low grade or follicular B Re-assessment required after 24 months Prerequisites (tick boxes where appropriate)	-cell NHL
Rituximab is to be used for maintenar chemotherapy	nce in CD20+ low grade or follicular B-cell NHL following induction with first-line systemic
O Patient is intended to receive rituxima 12 cycles)	ab maintenance therapy for 2 years at a dose of 375 mg/m2 every 8 weeks (maximum of
INITIATION – Membranous nephropathy Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate)	
or	ary/idiopathic membranous nephropathy* ith no evidence of secondary cause, and an eGFR of > 60ml/min/1.73m2
and Patient remains at high risk of progres measures (see Note) and	ssion to end-stage kidney disease despite more than 3 months of treatment with conservative
\sim	acceed the equivalent of 375mg/m2 of body surface area per week for a total of 4 weeks
CONTINUATION – Membranous nephropathy Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate)	
Patient was previously treated with rit	uximab for membranous nephropathy*
O Treatment with rituximab was p	reviously successful, but the condition has relapsed, and the patient now requires repeat
O Patient achieved partial response	se to treatment and requires repeat treatment (see Note)
and O The total rituximab dose used would r	not exceed the equivalent of 375 mg/m2 of body surface area per week for a total of 4 weeks
Note:	
a) Indications marked with * are unapproved indication	
b) High risk of progression to end-stage kidney disea	
	system blockade, blood-pressure management, dietary sodium and protein restriction, treatment of contraindicated or the patient has experienced intolerable side effects.
d) Partial response defined as a reduction of protein	uria of at least 50% from baseline, and between 0.3 grams and 3.5 grams per 24 hours.

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:		
Rituximab (Riximyo) - continued			
INITIATION – B-cell acute lymphoblastic leukaemia/ly Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)	mphoma*		
and Treatment must be in combination with ar and	O Treatment must be in combination with an intensive chemotherapy protocol with curative intent and O The total rituximab dose would not exceed the equivalent of 375 mg/m2 per dose for a maximum of 18 doses		
INITIATION – desensitisation prior to transplant Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate) O Patient requires desensitisation prior to m and			
O Patient would receive no more than two d Note: Indications marked with * are unapproved indicatio			
by the Health NZ Hospital.	igist or relevant specialist, or in accordance with a protocol or guideline that has been endorsed		
and Patient has severe rapidly progress and Is used in combination with system and O Skin involvement is at least 5 or O Significant mucosal involvem or O Involvement of two or more m	ic corticosteroids (20 mg/day) % body surface area ent (10 or more mucosal erosions) or diffuse gingivitis or confluent large erosions		
or Patient has pemphigus and Patient has not experienced adequations sparing agent, unless contraindications Note: Indications marked with * are unapproved indication			

I confirm that the above details are correct:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Rituximab (Riximyo) - continued	
CONTINUATION – pemiphigus* Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a dermatologist or relevant spect by the Health NZ Hospital.	ialist, or in accordance with a protocol or guideline that has been endorsed
O Patient has experienced adequate clinical benefit from rituxim ulceration and reduction in corticosteroid requirement and O Patient has not received rituximab in the previous 6 months Note: Indications marked with * are unapproved indications.	ab treatment, with improvement in symptoms and healing of skin
INITIATION – immunoglobulin G4-related disease (IgG4-RD*) Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate)	
And Patient has confirmed diagnosis of IgG4-RD*	anti-rheumatic drugs for at least 3 months has been ineffective in
Or Treatment with corticosteroids and/or disease modifying toxicity or intolerance	anti-rheumatic drugs is contraindicated or associated with evidence of
Total rituximab dose used should not exceed a maximum of two	vo 1000 mg infusions of rituximab given two weeks apart
Note: Indications marked with * are unapproved indications.	
CONTINUATION – immunoglobulin G4-related disease (IgG4-RD*) Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
O Treatment with rituximab for IgG4-RD* was previously s but the condition has relapsed	uccessful and patient's disease has demonstrated sustained response,
O Patient is receiving maintenance treatment for IgG4-RD	*
and Rituximab re-treatment not to be given within 6 months of prev and	
Maximum of two 1000 mg infusions of rituximab given two we	eks apart
Note: Indications marked with * are unapproved indications.	

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.	

ESCRIBER	PATIENT:
me:	Name:
rd:	NHI:
polizumab	
TIATION – Severe eosinophilic asthma e-assessment required after 12 months erequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a respiratory physician o endorsed by the Health NZ Hospital.	or clinical immunologist, or in accordance with a protocol or guideline that has bee
A Patient must be aged 12 years or older	
	asthma documented by a respiratory physician or clinical immunologist
\sim	tion, central airway obstruction, bronchiolitis etc. have been excluded
O Patient has a blood eosinophil count of greater than 0.	.5 × 10 [°] 9 cells/L in the last 12 months
 Patient must be adherent to optimised asthma therapy of fluticasone propionate) plus long acting beta-2 agor therapy regimen, unless contraindicated or not tolerate and 	r including inhaled corticosteroids (equivalent to at least 1000 mcg per day nist, or budesonide/formoterol as part of the single maintenance and reliever ed
O Patient has had at least 4 exacerbations needing	g systemic corticosteroids in the previous 12 months, where an exacerbation is osteroids for at least 3 days or parenteral corticosteroids
	oids of at least the equivalent of 10 mg per day over the previous 3 months
and O Treatment is not to be used in combination with subsic	dised benralizumab
O Patient has an Asthma Control Test (ACT) score of 10	or less. Baseline measurements of the patient's asthma control using the ACT of application, and again at around 52 weeks after the first dose to assess
	piological therapy for their severe eosinophilic asthma
O Patient was refractory or intolerant to prev	ious anti-IL5 biological therapy
	ent with previous anti-IL5 biological therapy and discontinued within

Re-assessment required after 2 years

Prerequisites (tick boxes where appropriate)

Prescribed by, or recommended by a respiratory physician or clinical immunologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. ()and

์ and	С	An in	acrease in the Asthma Control Test (ACT) score of at least 5 from baseline
	or	Ο	Exacerbations have been reduced from baseline by 50% as a result of treatment with mepolizumab
	or	Ο	Reduction in continuous oral corticosteroid use by 50% or by 10 mg/day while maintaining or improving asthma control

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:
Mepolizumab - continued	
INITIATION – eosinophilic granulomatosis with polyangiitis Re-assessment required after 12 months	
Prerequisites (tick boxes where appropriate)	
O The patient has eosinophilic granulomatosis with polyangiitis	
and The patient has trialled and not received adequate benefit fr contraindicated to all): azathioprine, cyclophosphamide, lefl and	om at least one of the following for at least three months (unless unomide, methotrexate, mycophenolate, or rituximab
The patient has trialled prednisone for a minimum of t 7.5 mg per day	nree months and is unable to maintain disease control at doses below
O Corticosteroids are contraindicated	
CONTINUATION – eosinophilic granulomatosis with polyangiitis Re-assessment required after 12 months Prerequisites (tick box where appropriate)	
O Patient has no evidence of clinical disease progression	

I confirm that the above details are correct:

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:
Casirivimab and imdevimab	
INITIATION – Treatment of profoundly immunocompromised patients Re-assessment required after 2 weeks	
Prerequisites (tick boxes where appropriate)	
Patient has confirmed (or probable) COVID-19	
The patient is in the community (treated as an outpatient) with and	n mild to moderate disease severity*
O Patient is profoundly immunocompromised** and is at risk of COVID-19 or is unvaccinated	not having mounted an adequate response to vaccination against
O Patient's symptoms started within the last 10 days	
O Patient is not receiving high flow oxygen or assisted/mechanic	cal ventilation
Casirivimab and imdevimab is to be administered at a maxim	um dose of no greater than 2,400 mg
Note: * Mild to moderate disease severity as described on the Ministry of Heat ** Examples include B-cell depletive illnesses or patients receiving treatment	
INITIATION – mild to moderate COVID-19-hospitalised patients Re-assessment required after 2 weeks Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by any relevant practitioner, or in a NZ Hospital.	ccordance with a protocol or guideline that has been endorsed by the Health
Patient has confirmed (or probable) COVID-19	
O Patient is an in-patient in hospital with mild to moderate disea	se severity*
Patient's symptoms started within the last 10 days	

and	Ο	Patie	ent is not receiving high flow oxygen or assisted/mechanical ventilation
		0	Age > 50
	or	0	BMI > 30
	or	0	Patient is Māori or Pacific ethnicity
	or	0	Patient is at increased risk of severe illness from COVID-19, excluding pregnancy, as described on the Ministry of Health website (see Notes)
and	1		
		0	Patient is unvaccinated
	or	0	Patient is seronegative where serology testing is readily available or strongly suspected to be seronegative where serology testing is not available

and Casirivimab and imdevimab is to be administered at a maximum dose of no greater than 2,400 mg Note: * Mild to moderate disease severity as described on the <u>Ministry of Health Website</u> **(<u>https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-information-specific-audiences/covid-19-advicehigher-risk-people</u>)

RS2063 - Adalimumab (Amgevita)

Arthritis - oligoarticular course juvenile idiopathic - INITIATION	383
Arthritis - oligoarticular course juvenile idiopathic - CONTINUATION	
Arthritis - polyarticular course juvenile idiopathic - INITIATION	
Arthritis - polyarticular course juvenile idiopathic - CONTINUATION	
Arthritis - psoriatic - INITIATION	
Arthritis - psoriatic - CONTINUATION	
Arthritis - rheumatoid - INITIATION	
Arthritis - rheumatoid - CONTINUATION	
Behcet's disease - severe - INITIATION	
Crohn's disease - adults - INITIATION	
Crohn's disease - adults - CONTINUATION	
Crohn's disease - children - INITIATION	
Crohn's disease - children - CONTINUATION	
Crohn's disease - fistulising - INITIATION	
Crohn's disease - fistulising - CONTINUATION	
Hidradenitis suppurativa - INITIATION	
Hidradenitis suppurativa - CONTINUATION	
Ocular inflammation - chronic - INITIATION	
Ocular inflammation - chronic - CONTINUATION	
Ocular inflammation - severe - INITIATION	
Ocular inflammation - severe - CONTINUATION	
Plaque psoriasis - severe chronic - INITIATION	
Plaque psoriasis - severe chronic - CONTINUATION	
Still's disease - adult-onset (AOSD) - INITIATION	
Ankylosing spondylitis - INITIATION	
Ankylosing spondylitis - CONTINUATION Inflammatory bowel arthritis – axial - INITIATION	
Inflammatory bowel arthritis – axial - INITIATION	
Inflammatory bowel arthritis - axial - CONTINUATION	
Inflammatory bowel arthritis - peripheral - INITIATION	
Inflammatory bowel arthritis – peripheral - CONTINUATION Pyoderma gangrenosum - INITIATION Ulcerative colitis - INITIATION	
Pyoderma gangrenosum - INITIATION	
Ulcerative colitis - CONTINUATION	
Undifferentiated spondyloarthiritis - INITIATION	
Undifferentiated spondyloarthiritis - CONTINUATION	
	j

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:

Adalimumab (Amgevita)

INITIATION – Behcet's disease - severe Prerequisites (tick boxes where appropriate)

O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

und	(and	С	The p	patient has severe Behcet's disease* that is significantly impacting the patient's quality of life
		~ "	0	The patient has severe ocular, neurological, and/or vasculitic symptoms and has not responded adequately to one or more treatment(s) appropriate for the particular symptom(s)
		or	0	The patient has severe gastrointestinal, rheumatological and/or mucocutaneous symptoms and has not responded adequately to two or more treatments appropriate for the particular symptom(s)
Note	Indic	ation	ns ma	rked with * are unapproved indications.

INITIATION – Hidradenitis suppurativa

and

and

Re-assessment required after 4 months

Prerequisites (tick boxes where appropriate)

C	Prescribed by, or recommended by a dermatologist.	, or in accordance	with a protocol or g	uideline that has been	endorsed by the Health NZ
	Hospital.				
and	-				

C	\mathcal{I}	Patient has hidradenitis suppurativa Hurley Stage II or Hurley Stage III lesions in distinct anatomic areas
and		
(J	Patient has tried, but had an inadequate response to at least a 90 day trial of systemic antibiotics or patient has demonstrated
		intolerance to or has contraindications for systemic antibiotics

O Patient has 3 or more active lesions

The patient has a DLQI of 10 or more and the assessment is no more than 1 month old at time of application

	CONTINUATION – Hidradenitis suppurativa Re-assessment required after 2 years				
F	Prerequisites (tick boxes where appropriate)				
a	O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
	O The patient has a reduction in active lesions (e.g. inflammatory nodules, abscesses, draining fistulae) of 25% or more from baseline O The patient has a DLQI improvement of 4 or more from baseline				

PRESCRIBER					PATIENT:
Name	e:				Name:
Ward	:				NHI:
Adal	imur	mab	(An	ngev	ita) - continued
Re-a	issess	ment r	equ	ired af	ter 4 months vhere appropriate)
(and		Prescri Hospita		by, or	recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
		(and	С	Patie	nt has had an initial Special Authority approval for etanercept for severe chronic plaque psoriasis
			or	0 0	Patient has experienced intolerable side effects Patient has received insufficient benefit to meet the renewal criteria for etanercept for severe chronic plaque psoriasis
	or				
			or	0	Patient has "whole body" severe chronic plaque psoriasis with a (PASI) score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis
			or	0	Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis
				0	Patient has severe chronic localised genital or flexural plaque psoriasis where the plaques or lesions have been present for at least 6 months from the time of initial diagnosis, and with a Dermatology Life Quality Index (DLQI) score greater than 10
		and (С		nt has tried, but had an inadequate response to, or has experienced intolerable side effects from, at least three of the ring (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, ciclosporin, or acitretin
		(С		SI assessment or (DLQI) assessment has been completed for at least the most recent prior treatment course but no or than 1 month following cessation of each prior treatment course and is no more than 1 month old at the time of cation

PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Adalimumab (Amgevita) - continued				
CONTINUATION – Plaque psoriasis - severe chronic Re-assessment required after 2 years				
Prerequisites (tick boxes where appropriate)				

O Patient had "whole body" severe chronic plaque psoriasis at the start of treatment			
		or	O The patient has experienced a 75% or more reduction in PASI score, or is sustained at this level, when compared with the pre-treatment baseline value
			O The patient has a DLQI improvement of 5 or more, when compared with the pre-treatment baseline value
or			
	(and	C	Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment
		or	O The patient has experienced a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the treatment course baseline values
			O The patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline value
or			
	O Patient had severe chronic localised genital or flexural plaque psoriasis at the start of treatment		
		or	O The patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline value
		U	O Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing adalimumab

INITIATION – pyoderma gangrenosum
Prerequisites (tick boxes where appropriate)
O Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
Patient has pyoderma gangrenosum* Patient has received three months of conventional therapy including a minimum of three pharmaceuticals (e.g. prednisone, ciclosporin, azathioprine, or methotrexate) and not received an adequate response
Note: Indications marked with * are unapproved indications.

PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Adalimumab (Amgevita) - continued				
INITIATION – Crohn's disease - adults Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in a NZ Hospital. and	accordance with a protocol or guideline that has been endorsed by the Health			
O Patient has severe active Crohn's disease				
or	more than 50 cm of the small intestine e at risk of short gut syndrome with further bowel resection			
O Patient has an ileostomy or colostomy and has intestin and Patient has tried but had an inadequate response to, or has and corticosteroids	al inflammation			
CONTINUATION – Crohn's disease - adults Re-assessment required after 2 years Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the NZ Hospital.				
or CDAI score has reduced by 100 points from the CDAI score, adalimumab CDAI score is 150 or less, or HBI is 4 or less	or HBI score has reduced 3 points, from when the patient was initiated on			
or O The patient has demonstrated an adequate response to treat	tment, but CDAI score and/or HBI score cannot be assessed			
INITIATION - Crohn's disease - children Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
and O Paediatric patient has active Crohn's disease and O Patient has a PCDAI score of greater than or equal to 3	30			
or O Patient has extensive small intestine disease and O Patient has tried but had an inadequate response to, or has and corticosteroids	experienced intolerable side effects from, prior therapy with immunomodulators			

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:		
Adalimumab (Amgevita) - continued			
CONTINUATION – Crohn's disease - children Re-assessment required after 2 years Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in ac NZ Hospital.	cordance with a protocol or guideline that has been endorsed by the Health		
and O PCDAI score has reduced by 10 points from the PCDAI score or O PCDAI score is 15 or less or O The patient has demonstrated an adequate response to treatm			
INITIATION – Crohn's disease - fistulising Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in ac NZ Hospital. and O Patient has confirmed Crohn's disease and O Patient has one or more complex externally draining entr or O Patient has one or more rectovaginal fistula(e) or O Patient has complex peri-anal fistula	cordance with a protocol or guideline that has been endorsed by the Health erocutaneous fistula(e)		
A Baseline Fistula Assessment has been completed and is no	more than 1 month old at the time of application		
CONTINUATION - Crohn's disease - fistulising Re-assessment required after 2 years Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O The number of open draining fistulae have decreased from baseline by at least 50% or O There has been a marked reduction in drainage of all fistula(e) from baseline as demonstrated by a reduction in the Fistula Assessment score, together with less induration and patient-reported pain			

X

or

or

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.

PRE	SCRIE	BER			PATIENT:		
Name	ə:				Name:		
Ward	:				NHI:		
Ada	limu	mab	(Ar	nge	gevita) - continued		
					inflammation - chronic red after 4 months		
Prer	equis	sites	tick t	oxe	oxes where appropriate)		
and		Presc NZ Ho			by, or recommended by any relevant practitioner, or in accordance with a protocol	or guideline that has been endorsed by the Health	
	or	0	The	patie	atient has had an initial Special Authority approval for infliximab for chronic ocular	inflammation	
	and		loss		Patient has severe uveitis uncontrolled with treatment of steroids and other immur loss	osuppressants with a severe risk of vision	
O Patient is 18 years or older and treatment with at least two other immunomodulatory agents has pr		dulatory agents has proven ineffective					
			or	С	O Patient is under 18 years and treatment with methotrexate has proven ineffe	ctive or is not tolerated at a therapeutic dose	
				С	O Patient is under 8 years and treatment with steroids or methotrexate has protected therapeutic dose; or disease requires control to prevent irreversible vision lo methotrexate		
					cular inflammation - chronic red after 2 years		
Prer	equis	sites	tick t	oxe	oxes where appropriate)		
and		Presc NZ Ho			by, or recommended by any relevant practitioner, or in accordance with a protocol	or guideline that has been endorsed by the Health	
	O The patient has had a good clinical response following 12 weeks' initial treatment						

Following each 2 year treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema)

Following each 2 year treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old

I confirm that the above details are correct:

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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.

PRES	SCRI	BER	PATIENT:		
Name	lame: Name:				
Ward	:		NHI:		
Ada	limu	ımab	b (Amgevita) - continued		
Re-a	asses	smen	Ocular inflammation - severe at required after 4 months (tick boxes where appropriate)		
O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed NZ Hospital.					
	or	0	Patient has had an initial Special Authority approval for infliximab for severe ocular inflammation		
		an	O Patient has severe, vision-threatening ocular inflammation requiring rapid control		
			Treatment with high-dose steroids (intravenous methylprednisolone) followed by high dose oral steroids has proven ineffective at controlling symptoms		
	O Patient developed new inflammatory symptoms while receiving high dose steroids				
			O Patient is aged under 8 years and treatment with high dose oral steroids and other immunosuppressants has proven ineffective at controlling symptoms		
CONTINUATION – Ocular inflammation - severe Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)					
Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the H NZ Hospital.					
	or	Ο	The patient has had a good clinical response following 3 initial doses		
		0	Following each 2 year treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema)		

Following each 2 year treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old

I confirm that the above details are correct:

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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.

PRESCRIE	BER	PATIENT:		
Name:				
Ward:		NHI:		
Adalimu	mab (Ar	ngevita) - continued		
Re-assess	sment requ	osing spondylitis ired after 6 months poxes where appropriate)		
	Prescribed Hospital.	by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ		
	() and	Patient has had an initial Special Authority approval for etanercept for ankylosing spondylitis		
	or	O The patient has experienced intolerable side effects		
		O The patient has received insufficient benefit to meet the renewal criteria for ankylosing spondylitis		
or				
	O Patient has a confirmed diagnosis of ankylosing spondylitis for more than six months and			
	 Patient has low back pain and stiffness that is relieved by exercise but not by rest and Patient has bilateral sacroiliitis demonstrated by radiology imaging and Patient has not responded adequately to treatment with two or more NSAIDs, while patient was undergoing at least 3 months of a regular exercise regimen for ankylosing spondylitis 			
	and	O Patient has limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by the following BASMI measures: a modified Schober's test of less than or equal to 4 cm and lumbar side flexion measurement of less than or equal to 10 cm (mean of left and right)		
		O Patient has limitation of chest expansion by at least 2.5 cm below the average normal values corrected for age and gender		
	A BASDAI of at least 6 on a 0-10 scale completed after the 3 month exercise trial, but prior to ceasing any previous pharmacological treatment and is no more than 1 month old at the time of application			
		inkylosing spondylitis ired after 2 years		
	•	pox where appropriate)		
\bigcirc	Prescribed	by or recommended by any relevant practitioner, or in accordance with a protocol or quideline that has been endorsed by the Health		

Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

For applications where treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10 point scale, or an improvement in BASDAI of 50%, whichever is less

and

 \bigcirc

PRESC	RIBE	ER PATIENT:			
Name:		Name:			
Ward:		NHI:			
Adalim	um	nab (Amgevita) - continued			
INITIAT Re-asse	r	 Arthritis - oligoarticular course juvenile idiopathic ment required after 6 months tes (tick boxes where appropriate) rescribed by, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed y the Health NZ Hospital. The patient has had an initial Special Authority approval for etanercept for oligoarticular course juvenile idiopathic arthritis (JIA) and Patient has experienced intolerable side effects Patient has received insufficient benefit to meet the renewal criteria for oligoarticular course JIA To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance and Patient has had oligoarticular course JIA for 6 months duration or longer and At least 2 active joints with limited range of motion, pain or tenderness after a 3-month trial of methotrexate (at the maximum tolerated dose) Moderate or high disease activity (CJADAS10 score greater than 1.5) with poor prognostic features after a 3-month trial of methotrexate (at the maximum tolerated dose) 			
Re-asse	CONTINUATION – Arthritis - oligoarticular course juvenile idiopathic Re-assessment required after 2 years Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Heal				
and	С	 Z Hospital. Pollowing initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baseline On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline 			

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.

PRES	CRIE	ER	PATIENT:	
Name	:		Name:	
Ward:				
Adal	imuı	nab (A	gevita) - continued	
INITI Re-a	ATIO ssess equis	N – Arth ment rec ites (tick Prescribe	s - polyarticular course juvenile idiopathic ed after 6 months xes where appropriate) y, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed NZ Hospital.	
		and c	Patient has had an initial Special Authority approval for etanercept for polyarticular course juvenile idiopathic arthritis (JIA) O Patient has experienced intolerable side effects O Patient has received insufficient benefit to meet the renewal criteria for polyarticular course JIA	
	or	and and c	To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance Patient has had polyarticular course JIA for 6 months duration or longer O At least 5 active joints and at least 3 joints with limited range of motion, pain or tenderness after a 3-month trial of methotrexate (at the maximum tolerated dose) O Moderate or high disease activity (cJADAS10 score of at least 2.5) after a 3-month trial of methotrexate (at the	
Re-a	ssess	ment rec	maximum tolerated dose) C Low disease activity (cJADAS10 score between 1.1 and 2.5) after a 6-month trial of methotrexate thritis - polyarticular course juvenile idiopathic ed after 2 years kes where appropriate)	
(Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			

O Following initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baseline

On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline

I confirm that the above details are correct:

and

or

Use this checklist to determine if a patient meets the restrictions for funding in th Schedule. For community funding, see the Special Authority Criteria.	e hospital setting . For more details, refer to Section H of the Pharmaceutical
PRESCRIBER	PATIENT:

FNE		EN	FAILENT.
Name	e:		
Ward	:		NHI:
Ada	limur	nab (An	ngevita) - continued
Re-a	assess requisi	ment requ ites (tick b	tis - psoriatic ired after 6 months oxes where appropriate) by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
		and	Patient has had an initial Special Authority approval for etanercept or secukinumab for psoriatic arthritis
		or	 O Patient has experienced intolerable side effects O Patient has received insufficient benefit to meet the renewal criteria for psoriatic arthritis
	or	and and and	Patient has had active psoriatic arthritis for six months duration or longer Patient has tried and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated) Patient has tried and not responded to at least three months of sulfasalazine or leflunomide at maximum tolerated doses (unless contraindicated)
		or	 Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen joints Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip
		and or or	 Patient has CRP level greater than 15 mg/L measured no more than one month prior to the date of this application Patient has an elevated ESR greater than 25 mm per hour ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months
Re-a	assess	ment requ	rthritis - psoriatic ired after 2 years oxes where appropriate)
and	O F		by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
	or (respo	wing initial treatment, the patient has at least a 50% decrease in swollen joint count from baseline and a clinically significant onse in the opinion of the physician nt demonstrates at least a continuing 30% improvement in swollen joint count from baseline and a clinically significant response
			opinion of the treating physician

I confirm that the above details are correct:

Signed:	Date:
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Use this checklist to determine if a patient meets the restrictions for funding in th Schedule. For community funding, see the Special Authority Criteria.	e hospital setting . For more details, refer to Section H of the Pharmaceutical
DECODIDED	DATIENT

rd: alimumab (A ITIATION – Arth e-assessment rec erequisites (tick O Prescribe Hospital. d and	Name: NHI: Amgevita) - continued thritis - rheumatoid equired after 6 months ck boxes where appropriate) beed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ I. O The patient has had an initial Special Authority approval for etanercept for rheumatoid arthritis
alimumab (A ITIATION – Arth e-assessment rec erequisites (tick O Prescribe Hospital. d and	Amgevita) - continued thritis - rheumatoid equired after 6 months ck boxes where appropriate) bed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ I.
TIATION – Arth e-assessment rec erequisites (tick O Prescribe Hospital. d and	thritis - rheumatoid equired after 6 months ck boxes where appropriate) bed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ I.
e-assessment rec erequisites (tick O Prescribe Hospital. d and	equired after 6 months ck boxes where appropriate) bed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ I.
	The patient has had an initial Special Authority approval for etanercept for rheumatoid arthritis
(O The patient has experienced intolerable side effects
	O The patient has received insufficient benefit from etanercept to meet the renewal criteria for rheumatoid arthritis
or and and and and and	 Patient has had rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic citrullinated peptide (CCP) antibody positive) for six months duration or longer Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance Patient has tried and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated) Patient has tried and not responded to at least three months of methotrexate in combination with sulfasalazine and hydroxychloro sulphate at maximum tolerated doses (unless contraindicated)
	 Patient has tried and not responded to at least three months of methotrexate in combination with the maximum tolerated dose of ciclosporin Patient has tried and not responded to at least three months of therapy at the maximum tolerated dose of leflunomide alone or in combination with methotrexate
and	 O Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen joints O Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip

(and	O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been NZ Hospital.					
	or	0	Following initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician			
		0	On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician			

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.

PRESCR	RIBEF	R PATIENT:
Name: .		Name:
Ward:		NHI:
Adalim	numa	ab (Amgevita) - continued
		- Still's disease - adult-onset (AOSD)
Prerequ	uisite	es (tick boxes where appropriate)
and		escribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ spital.
	a	O The patient has had an initial Special Authority approval for etanercept and/or tocilizumab for (AOSD)
		O Patient has experienced intolerable side effects from etanercept and/or tocilizumab
		O Patient has received insufficient benefit from at least a three-month trial of etanercept and/or tocilizumab
0	r _	
	a	O Patient diagnosed with AOSD according to the Yamaguchi criteria
		O Patient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, NSAIDs and methotrexate
	a	O Patient has persistent symptoms of disabling poorly controlled and active disease
Re-asse Prerequ	essme u isite Pre	 ulcerative colitis ent required after 6 months es (tick boxes where appropriate) escribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health Hospital.
and	Ond	Patient has active ulcerative colitis
		O Patient's SCCAI score is greater than or equal to 4
		O Patient's PUCAI score is greater than or equal to 20
	nd O	Patient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators and systemic corticosteroids
	\bigcirc	Surgery (or further surgery) is considered to be clinically inappropriate
		FION – ulcerative colitis ent required after 2 years
	u isite Pre	es (tick boxes where appropriate) escribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
	u isite Pre	es (tick boxes where appropriate)

April	2025		RESTRICTIONS CHECKLIST
			ist to determine if a patient meets the restrictions for funding in the hospital setting . For more details, refer to Section H of the Pharmaceutica community funding, see the Special Authority Criteria.
PRES	SCRI	BER	PATIENT:
Name	e:		Name:
Ward	:		NHI:
Ada	imu	ımat	b (Amgevita) - continued
Re-a	sses	smen	undifferentiated spondyloarthiritis nt required after 6 months (tick boxes where appropriate)
and	С С	Preso Hosp	cribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ bital.
	and		Patient has undifferentiated peripheral spondyloarthritis* with active peripheral joint arthritis in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip
	and	O t	Patient has tried and not responded to at least three months of each of methotrexate, sulphasalazine and leflunomide, at maximum tolerated doses (unless contraindicated)
		or	O Patient has a CRP level greater than 15 mg/L measured no more than one month prior to the date of this application
		or	$\hat{\mathbf{Q}}$
			O ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months
Note	: Inc	licatio	ons marked with * are unapproved indications.
Re-a	isses	smen	DN – undifferentiated spondyloarthiritis ht required after 2 years (tick boxes where appropriate)
and	С С		cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health Hospital.
	or	0	Following initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician
		0	The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response in the opinion of the treating physician
Re-a	sses	smen	inflammatory bowel arthritis – axial nt required after 6 months
Prer	equi	sites	(tick boxes where appropriate)
and	5	Preso Hosp	cribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ bital.
		0	Patient has a diagnosis of active ulcerative colitis or active Crohn's disease
	and	0	Patient has axial inflammatory pain for six months or more
	and	Ο	Patient is unable to take NSAIDs
	and	Ο	Patient has unequivocal sacroiliitis demonstrated by radiological imaging or MRI
		0	Patient has not responded adequately to prior treatment consisting of at least 3 months of an exercise regime supervised by a physiotherapist
	and	Ó	A BASDAI of at least 6 on a 0-10 scale completed after the 3 month exercise trial, but prior to ceasing any previous pharmacological treatment

RESCRI	BER		PATIENT:
lame:			Name:
Vard:			NHI:
dalimu	umab (<i>l</i>	Amgevita) - continued	
Re-asses	sment re	– inflammatory bowel arthritis – axial equired after 2 years k box where appropriate)	
and	NZ Hosp Where tr	pital.	tioner, or in accordance with a protocol or guideline that has been endorsed by the Healt ASDAI of 4 or more points from pre-treatment baseline on a 10 point scale, or an
Re-asses	sment re	ammatory bowel arthritis – peripheral equired after 6 months k boxes where appropriate)	
Re-asses Prerequia	ssment re sites (tic Prescrib Hospital	equired after 6 months k boxes where appropriate) ed by, or recommended by a rheumatologist, o	or in accordance with a protocol or guideline that has been endorsed by the Health NZ
Re-asses Prerequia	ssment re sites (tic Prescrib Hospital.	equired after 6 months k boxes where appropriate) ed by, or recommended by a rheumatologist, o tient has a diagnosis of active ulcerative colitient	
Ne-asses Prerequis	A Constant of the second secon	equired after 6 months k boxes where appropriate) ed by, or recommended by a rheumatologist, o tient has a diagnosis of active ulcerative colitient tient has active arthritis in at least four joints f ernoclavicular	s or active Crohn's disease
rerequis	Prescrib Hospital Prescrib Hospital Pa Pa d Pa d Pa d Pa d C Pa	equired after 6 months k boxes where appropriate) ed by, or recommended by a rheumatologist, o tient has a diagnosis of active ulcerative colitient attent has active arthritis in at least four joints f ernoclavicular tient has tried and not experienced a respons use (unless contraindicated)	s or active Crohn's disease rom the following: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder,
Ne-asses Prerequision and and and and and	Prescrib Hospital Prescrib Hospital Pa Pa d Pa d Pa d Pa d C Pa	equired after 6 months k boxes where appropriate) ed by, or recommended by a rheumatologist, o ttient has a diagnosis of active ulcerative coliti- ttient has active arthritis in at least four joints f ernoclavicular ttient has tried and not experienced a respons se (unless contraindicated) ttient has tried and not experienced a respons ntraindicated)	s or active Crohn's disease rom the following: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder, e to at least three months of methotrexate, or azathioprine at a maximum tolerated
Re-asses Prerequision	ssment re sites (tic Prescrib Hospital. Pa d Pa d Pa d Pa d C Pa	equired after 6 months k boxes where appropriate) ed by, or recommended by a rheumatologist, o ttient has a diagnosis of active ulcerative coliti- ttient has a diagnosis of active ulcerative coliti- ttient has active arthritis in at least four joints f ernoclavicular ttient has tried and not experienced a respons se (unless contraindicated) ttient has tried and not experienced a respons ntraindicated)	s or active Crohn's disease rom the following: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder, e to at least three months of methotrexate, or azathioprine at a maximum tolerated e to at least three months of sulphasalazine at a maximum tolerated dose (unless g/L measured no more than one month prior to the date of this application

Re-assessment required after 2 years

Prerequisites (tick boxes where appropriate)

and

or ()

Ο	Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
	NZ Hospital.

O Following initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician

Patient demonstrates at least a continuing 30% improvement in active joint count from baseline in the opinion of the treating physician

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:

Palivizumab

and	$\overline{\mathbf{A}}$			where appropriate) to be administered during the annual RSV season
anu	or	and	С О	Infant was born in the last 12 months Infant was born at less than 32 weeks zero days' gestation
		and	C or	Child was born in the last 24 months O Child has severe lung, airway, neurological or neuromuscular disease that requires ongoing ventilatory/respiratory support (see Note A) in the community O Child has haemodynamically significant heart disease
				and O Child has unoperated simple congenital heart disease with significant left to right shunt (see Note B) or O Child has unoperated or surgically palliated complex congenital heart disease or O Child has severe pulmonary hypertension (see Note C) or O Child has moderate or severe left ventricular (LV) failure (see Note D)
			or or	 Child has severe combined immune deficiency, confirmed by an immunologist, but has not received a stem cell transplant Child has inborn errors of immunity (see Note E) that increase susceptibility to life-threatening viral respiratory infections, confirmed by an immunologist

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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.

PRESCRIE	BER		PATIENT:
Name:			
Ward:			NHI:
Palivizur	nab	- conti	inued
	sment sites (require tick bo	ed after 6 months xes where appropriate) umab to be administered during the annual RSV season
and	O	0 0	vas born in the last 24 months Child has severe lung, airway, neurological or neuromuscular disease that requires ongoing ventilatory/respiratory support (see Note A) in the community O Child has haemodynamically significant heart disease or O Child has unoperated simple congenital heart disease with significant left to right shunt (see Note B) or O Child has unoperated or surgically palliated complex congenital heart disease or O Child has severe pulmonary hypertension (see Note C)
	or or	0 0	Child has moderate or severe left ventricular (LV) failure (see Note D) Child has severe combined immune deficiency, confirmed by an immunologist, but has not received a stem cell transplant Child has inborn errors of immunity (see Note E) that increase susceptibility to life-threatening viral respiratory infections, confirmed by an immunologist

Note:

- a) Ventilatory/respiratory support includes those on home oxygen, CPAP/VPAP and those with tracheostomies in situ managed at home
- b) Child requires/will require heart failure medication, and/or child has significant pulmonary hypertension, and/or infant will require surgical palliation/definitive repair within the next 3 months
- c) Mean pulmonary artery pressure more than 25 mmHg
- d) LV Ejection Fraction less than 40%
- e) Inborn errors of immunity include, but are not limited to, IFNAR deficiencies

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:

Gemtuzumab ozogamicin

INITIATION Prerequisites (tick boxes where appropriate) () Patient has not received prior chemotherapy for this condition and Patient has de novo CD33-positive acute myeloid leukaemia and Patient does not have acute promyelocytic leukaemia and Gemtuzumab ozogamicin will be used in combination with standard anthracycline and cytarabine (AraC) and Patient is being treated with curative intent and Patient's disease risk has been assessed by cytogenetic testing to be good or intermediate and Patient must be considered eligible for standard intensive remission induction chemotherapy with standard anthracycline and cytarabine (AraC) and Gemtuzumab ozogamicin to be funded for one course only (one dose at 3 mg per m² body surface area or up to 2 vials of 5 mg as separate doses)

Note: Acute myeloid leukaemia excludes acute promyelocytic leukaemia and acute myeloid leukaemia that is secondary to another haematological disorder (eg myelodysplasia or myeloproliferative disorder).

I confirm that the above details are correct:

Use this checklist to determine if a patient meets the restrictions for funding in the hospital setting	J. For more details, refer to Section H of the Pharmaceutica
Schedule. For community funding, see the Special Authority Criteria.	

ESCRIBER	PATIENT:
me:	Name:
ırd:	NHI:
nralizumab	
TIATION – Severe eosinophilic asthma e-assessment required after 12 months erequisites (tick boxes where appropriate)	
 Prescribed by, or recommended by a respiratory physician endorsed by the Health NZ Hospital. Id 	or clinical immunologist, or in accordance with a protocol or guideline that has been
O Patient must be aged 12 years or older	
and O Patient must have a diagnosis of severe eosinophilic and	asthma documented by a respiratory physician or clinical immunologist
	ction, central airway obstruction, bronchiolitis etc. have been excluded
O Patient has a blood eosinophil count of greater than and	0.5×10^{9} cells/L in the last 12 months
	by including inhaled corticosteroids (equivalent to at least 1000 mcg per day of ist, or budesonide/formoterol as part of the anti-inflammatory reliever therapy plus tolerated
O Patient has had at least 4 exacerbations needi	ing systemic corticosteroids in the previous 12 months, where an exacerbation is costeroids for at least 3 days or parenteral corticosteroids
O Patient has received continuous oral corticoste	eroids of at least the equivalent of 10 mg per day over the previous 3 months
and O Treatment is not to be used in combination with subs	sidised mepolizumab
	0 or less. Baseline measurements of the patient's asthma control using the ACT ne of application, and again at around 52 weeks after the first dose to assess
	biological therapy for their severe eosinophilic asthma
And Patient was refractory or intolerant to pre	evious anti-IL5 biological therapy
O Patient was not eligible to continue treatr 12 months of commencing treatment	ment with previous anti-IL5 biological therapy and discontinued within

Re-assessment required after 2 years

Prerequisites (tick boxes where appropriate)

O Prescribed by, or recommended by a respiratory physician or clinical immunologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

(and	C	An in	crease in the Asthma Control Test (ACT) score of at least 5 from baseline
	or	Ο	Exacerbations have been reduced from baseline by 50% as a result of treatment with benralizumab
		0	Reduction in continuous oral corticosteroid use by 50% or by 10 mg/day while maintaining or improving asthma control

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:

Ustekinumab

Re-assessm	- Crohn's disease - adults nent required after 6 months es (tick boxes where appropriate)
or	Patient is currently on treatment with ustekinumab commenced prior to 1 February 2023 and met all remaining criteria (criterion 2) below at the time of commencing treatment
	O Patient has active Crohn's disease
	O Patient has had an initial approval for prior biologic therapy for Crohn's disease and has experienced intolerable side effects or insufficient benefit to meet renewal criteria
	O Patient meets the initiation criteria for prior biologic therapies for Crohn's disease and O Other biologics for Crohn's disease are contraindicated
Re-assessm	TION – Crohn's disease - adults nent required after 12 months es (tick boxes where appropriate)
	O CDAI score has reduced by 100 points, or HBI score has reduced by 3 points, from when the patient was initiated on biologic therapy or
	${ m O}$ CDAI score is 150 or less, or HBI is 4 or less
	or O The patient has experienced an adequate response to treatment, but CDAI score and/or HBI score cannot be assessed
and	Ustekinumab to be administered at a dose no greater than 90 mg every 8 weeks
Re-assessm	 – Crohn's disease - children* nent required after 6 months es (tick boxes where appropriate)
or	Patient is currently on treatment with ustekinumab commenced prior to 1 February 2023 and met all remaining criteria (criterion 2) below at the time of commencing treatment
	O Patient has active Crohn's disease
	O Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria
	Patient meets the initiation criteria for prior biologic therapies for Crohn's disease
	O Other biologics for Crohn's disease are contraindicated
Note: Indica	ation marked with * is an unapproved indication.

PRESCRIBER	PATIENT:	
lame:	Name:	
Vard:	NHI:	
Jstekinumal	b - continued	
CONTINUATIO Re-assessment	DN – Crohn's disease - children* at required after 12 months (tick boxes where appropriate)	
or or and	 O PCDAI score has reduced by 10 points from when the patient was initiated on bit O PCDAI score is 15 or less O The patient has experienced an adequate response to treatment, but CDAI score Ustekinumab to administered at a dose no greater than 90 mg every 8 weeks 	
Note: Indicatio	on marked with * is an unapproved indication.	
or	Patient is currently on treatment with ustekinumab commenced prior to 1 February 202 below at the time of commencing treatment	23 and met all remaining criteria (criterion 2)
and	or O Patient has had an initial approval for prior biologic therapy for ulcerative c effects or insufficient benefit to meet renewal criteria	
	O Other biologics for ulcerative colitis are contraindicated	
Re-assessment	DN – ulcerative colitis ht required after 12 months (tick boxes where appropriate)	
(
or	 O The SCCAI score has reduced by 2 points or more from the SCCAI score since i O PUCAI score has reduced by 10 points or more from the PUCAI score since initia 	

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:

Vedolizumab

(Ο	Patient has active Crohn's disease	
and	\square		in a ufficient la constitu
	or	 Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or meet renewal criteria (unless contraindicated) 	insuncient benefit
	-	O Patient has a CDAI score of greater than or equal to 300, or HBI score of greater than or equal to 10	
	or	m O Patient has extensive small intestine disease affecting more than 50 cm of the small intestine	
	or	O Patient has evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel res	section
	or	O Patient has an ileostomy or colostomy, and has intestinal inflammation	
and			
		O Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of from prior therapy with immunomodulators and corticosteroids	of initial response)
	or	O Patient has experienced intolerable side effects from immunomodulators and corticosteroids	
	or	O Immunomodulators and corticosteroids are contraindicated	
		N – Crohn's disease - adults required after 2 years	
		tick boxes where appropriate)	
		O CDAI score has reduced by 100 points, or HBI score has reduced by 3 points, from when the patient was in therapy	nitiated on biologic
	or		
		O CDAI score is 150 or less, or HBI is 4 or less	

O Vedolizumab to administered at a dose no greater than 300 mg every 8 weeks

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:	
Vedolizumab - continued		
(

requisi	ites O	(tick boxes where appropriate) Paediatric patient has active Crohn's disease
and	_	
		O Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria (unless contraindicated)
	or	O Patient has a Paediatric Crohn's Disease Activity Index (PCDAI) score of greater than or equal to 30
	or	O Patient has extensive small intestine disease
and	_	
	or	O Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response) from prior therapy with immunomodulators and corticosteroids
		O Patient has experienced intolerable side effects from immunomodulators and corticosteroids
	or	O Immunomodulators and corticosteroids are contraindicated
e: Indic	atio	n marked with * is an unapproved indication.
		NN – Crohn's disease - children*
		t required after 2 years (tick boxes where appropriate)
equisi	nes	(lick boxes where appropriate)
		O PCDAI score has reduced by 10 points from when the patient was initiated on biologic therapy
	or	O PCDAI score is 15 or less
	or	O The patient has experienced an adequate response to treatment, but CDAI score cannot be assessed

 ${
m O}\,$ Vedolizumab to administered at a dose no greater than 300mg every 8 weeks

Note: Indication marked with * is an unapproved indication.

and

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:	

Vedolizumab - continued

INITIATION – ulcerative colitis Re-assessment required after 6 months				
Prerequisites (tick boxes where appropriate)				
an	C	Patient has active ulcerative colitis		
		O Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria (unless contraindicated)		
		r O Patient has a SCCAI score is greater than or equal to 4		
		O Patient's PUCAI score is greater than or equal to 20*		
an	d		_	
		O Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response) from prior therapy with immunomodulators and corticosteroids		
		r O Patient has experienced intolerable side effects from immunomodulators and corticosteroids r		
		O Immunomodulators and corticosteroids are contraindicated		
Note: In	Note: Indication marked with * is an unapproved indication.			
Re-asse	ssm	ION – ulcerative colitis ent required after 2 years s (tick boxes where appropriate)		
		O The SCCAI score has reduced by 2 points or more from the SCCAI score since initiation on biologic therapy		
		O The PUCAI score has reduced by 10 points or more from the PUCAI score since initiation on biologic therapy *		
an	d C	Vedolizumab will be used at a dose no greater than 300 mg intravenously every 8 weeks	_	

Note: Indication marked with * is an unapproved indication.

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:		

Brentuximab

INITIATION – relapsed/refractory Hodgkin lymphoma Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)
O Patient has relapsed/refractory CD30-positive Hodgkin lymphoma after two or more lines of chemotherapy and O Patient is ineligible for autologous stem cell transplant
or O Patient has relapsed/refractory CD30-positive Hodgkin lymphoma and O Patient has previously undergone autologous stem cell transplant
 and Patient has not previously received funded brentuximab vedotin and Response to brentuximab vedotin treatment is to be reviewed after a maximum of 6 treatment cycles and Brentuximab vedotin to be administered at doses no greater than 1.8 mg/kg every 3 weeks
CONTINUATION – relapsed/refractory Hodgkin lymphoma Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)
 Patient has achieved a partial or complete response to brentuximab vedotin after 6 treatment cycles and Treatment remains clinically appropriate and the patient is benefitting from treatment and treatment is being tolerated Patient is to receive a maximum of 16 total cycles of brentuximab vedotin treatment
INITIATION – anaplastic large cell lymphoma Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)
Patient has relapsed/refractory CD30-positive systemic anaplastic large cell lymphoma and Patient has an ECOG performance status of 0-1

Patient has not previously received brentuximab vedotin

Response to brentuximab vedotin treatment is to be reviewed after a maximum of 6 treatment cycles

Brentuximab vedotin to be administered at doses no greater than 1.8 mg/kg every 3 weeks

and

and

and

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:			Name:		
Ward:			NHI:		
Brent	Brentuximab - continued				
CONTINUATION – anaplastic large cell lymphoma Re-assessment required after 9 months					
		(tick boxes where appropriate)			
	O Patient has achieved a partial or complete response to brentuximab vedotin after 6 treatment cycles				
	O Treatment remains clinically appropriate and the patient is benefitting from treatment and treatment is being tolerated				
a	and	Patient is to receive a maximum of 16 total cycles of brentuxim	ab vedotin treatment		

PRESCRIBER	SCRIBER PATIENT:		
Name:	Name:		
Ward:	NHI:		
F rastuzumab	(Herzuma)		
Re-assessment r	rly breast cancer equired after 12 months ck boxes where appropriate)		
and	he patient has early breast cancer expressing HER-2 IHC 3+ or ISH + (including FISH or other current technology flaximum cumulative dose of 106 mg/kg (12 months' treatment)		
Re-assessment r	- early breast cancer* equired after 12 months ck boxes where appropriate)		
and and and and	 The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology The patient received prior adjuvant trastuzumab treatment for early breast cancer The patient has not previously received lapatinib treatment for HER-2 positive metastatic breast cancer The patient discontinued lapatinib within 3 months due to intolerable side effects and the cancer did not progress whilst on lapatinib He cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab Trastuzumab will not be given in combination with pertuzumab Trastuzumab to be administered in combination with pertuzumab Patient has not received prior treatment for their metastatic disease and has had a treatment-free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer The patient has good performance status (ECOG grade 0-1) 		
or (and (and (Trastuzumab to be discontinued at disease progression Patient has previously discontinued treatment with trastuzumab in the metastatic setting for reasons other than severe toxicity or disease progression Patient has signs of disease progression Disease has not progressed during previous treatment with trastuzumab 		
Note: * For patien	nts with relapsed HER-2 positive disease who have previously received adjuvant trastuzumab for early breast cancer		

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:		
Trastuzumab (Herzuma) - continued			

O The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology) and		
		O The patient has not previously received lapatinib treatment for HER-2 positive metastatic breast cancer
	or	The patient discontinued lapatinib within 3 months due to intolerable side effects and the cancer did not progress whilst on lapatinib
and		
	O Trastuzumab will not be given in combination with pertuzumab or	
12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic brea		
		O Patient has not received prior treatment for their metastatic disease and has had a treatment-free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer and
		O The patient has good performance status (ECOG grade 0-1)

CONTINUATION – metastatic breast cancer

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

	and	The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)
	and	The cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab
	O	Trastuzumab to be discontinued at disease progression
or		
	and	Patient has previously discontinued treatment with trastuzumab for reasons other than severe toxicity or disease progression
	and	Patient has signs of disease progression
	0	Disease has not progressed during previous treatment with trastuzumab

INITIATION – gastric, gastro-oesophageal junction and oesophageal cancer Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)

Prerequisites (lick boxes where appropriate

 \bigcirc

and

The patient has locally advanced or metastatic gastric, gastro-oesophageal junction or oesophageal cancer expressing HER-2 IHC 2+ FISH+ or IHC3+ (or other current technology)

O Patient has an ECOG score of 0-2

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:		
Trastuzumab (Herzuma) - continued			
CONTINUATION – gastric, gastro-oesophageal junction and oesophageal cancer Re-assessment required after 12 months			
Prerequisites (tick boxes where appropriate)			
O The cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab			
And O Trastuzumab to be discontinued at disease progression			

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:

Trastuzumab deruxtecan

INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O Patient has metastatic breast cancer expressing HER-2 IHC3+ or ISH+ (including FISH or other current technology)	
and O Patient has previously received trastuzumab and chemotherapy, separately or in combination and	
O The patient has received prior therapy for metastatic disease	
O The patient developed disease recurrence during, or within six months of completing adjuvant therapy	
and Patient has a good performance status (ECOG 0-1)	
And O Patient has not received prior funded trastuzumab deruxtecan treatment	
O Treatment to be discontinued at disease progression	
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O The cancer has not progressed at any time point during the previous approval period whilst on trastuzumab deruxtecan and	

O Treatment to be discontinued at disease progression

Note: Prior or adjuvant therapy includes anthracycline, other chemotherapy, biological drugs, or endocrine therapy.

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:

Bevacizumab

	sment required after 6 months Isites (tick boxes where appropriate) Patient is currently on treatment with bevacizumab, and met all remaining criteria prior to commencing treatment Patient has locally advanced or metastatic, unresectable hepatocellular carcinoma Patient has preserved liver function (Child-Pugh A) Patient has preserved liver function (TACE) is unsuitable and Patient has not received prior systemic therapy for the treatment of hepatocellular carcinoma or Patient neceived funded lenvatinib before 1 March 2025 or Patient has experienced treatment-limiting toxicity from treatment with lenvatinib and Patient has an ECOG performance status of 0-2 and To be given in combination with atezolizumab
Re-asses Prerequi	UATION – unresectable hepatocellular carcinoma ssment required after 6 months isites (tick box where appropriate) No evidence of disease progression
Re-asses	DN – advanced or metastatic ovarian cancer esement required after 4 months isites (tick boxes where appropriate)

	O The patient has previously untreated advanced (FIGO Stage IIIB or IIIC) epithelial ovarian, fallopian tube, or primary peritoneal cancer
	and O Debulking surgery is inappropriate or
and	O The cancer is sub-optimally debulked (maximum diameter of any gross residual disease greater than 1cm)

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Bevacizumab - continued	
CONTINUATION – advanced or metastatic ovarian cancer Re-assessment required after 4 months	
Prerequisites (tick box where appropriate)	
O No evidence of disease progression	
INITIATION – Recurrent Respiratory Papillomatosis Re-assessment required after 12 months	
Prerequisites (tick boxes where appropriate)	
Maximum of 6 doses	
The patient has recurrent respiratory papillomatosis and	
O The treatment is for intra-lesional administration	
CONTINUATION – Recurrent Respiratory Papillomatosis	
Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
O Maximum of 6 doses	
The treatment is for intra-lesional administration	
There has been a reduction in surgical treatments or disease	regrowth as a result of treatment
INITIATION – Ocular Conditions	
Prerequisites (tick boxes where appropriate)	
O Ocular neovascularisation	
or O Exudative ocular angiopathy	
)

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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:

Inotuzumab ozogamicin

or

and

INITIATION

(and	С	Patient has relapsed or refractory CD22-positive B-cell acute lymphoblastic leukaemia/lymphoma, including minimal residual disease
and	С	Patient has ECOG performance status of 0-2
		O Patient has Philadelphia chromosome positive B-Cell ALL
		and O Patient has previously received a tyrosine kinase inhibitor
	or	O Patient has received one prior line of treatment involving intensive chemotherapy
and (C	Treatment is to be administered for a maximum of 3 cycles
and		
TINU	ATIO ment	
TINU	ATIO ment ites (N required after 4 months

O Patient has experienced complete remission with incomplete haematological recovery

m O Treatment with inotuzumab ozogamicin is to cease after a total duration of 6 cycles

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:
Basiliximab	
INITIATION Prerequisites (tick box where appropriate)	
${ m O}~$ For use in solid organ transplants	

PRESCE	RIBE	R	PATIENT:
Name: .			
Ward:			NHI:
Rituxin	nab	(Mabthe	era)
Re-asse	essm	ent requ	natoid arthritis - prior TNF inhibitor use ired after 4 months poxes where appropriate)
and		escribed spital.	by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
	a	and	The patient has had an initial community Special Authority approval for at least one of etanercept and/or adalimumab for rheumatoid arthritis
		or	 O The patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept O Following at least a four month trial of adalimumab and/or etanercept, the patient did not meet the renewal criteria for adalimumab and/or etanercept for rheumatoid arthritis
a	nd		
		Ö	Rituximab to be used as an adjunct to methotrexate or leflunomide therapy
		or ()	Patient is contraindicated to both methotrexate and leflunomide, requiring rituximab monotherapy to be used
a	nd) Maxi	mum of two 1,000 mg infusions of rituximab given two weeks apart

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.

			Name:
:			
d: NHI:			
ximab) (M	abthe	era) - continued
IATION Issessm	– rl nent	heum requ	natoid arthritis - TNF inhibitors contraindicated ired after 4 months noxes where appropriate)
	resc ospi		by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and)	Treatment with a Tumour Necrosis Factor alpha inhibitor is contraindicated	
and	\mathbf{C}	Patie citrull	nt has had severe and active erosive rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic inated peptide (CCP) antibody positive) for six months duration or longer
and			nt has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a mum tolerated dose
C)	Patie hydro	nt has tried and not responded to at least three months of oral or parenteral methotrexate in combination with sulfasalazine and paychloroquine sulphate (at maximum tolerated doses)
and	or	0	Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with the maximum tolerated dose of cyclosporin
	or	0	Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with intramuscula gold
	01	0	Patient has tried and not responded to at least three months of therapy at the maximum tolerated dose of leflunomide alone or in combination with oral or parenteral methotrexate
and		_	
	or	Ο	Patient has persistent symptoms of poorly controlled and active disease in at least 20 swollen, tender joints
	01	0	Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip
and			
	or	0	Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application
		0	C-reactive protein levels not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months
and		0	
	or	0	Rituximab to be used as an adjunct to methotrexate or leflunomide therapy
		O	Patient is contraindicated to both methotrexate and leflunomide, requiring rituximab monotherapy to be used

	BER			PATIENT:
ə:				Name:
:				NHI:
xima	3 b (N	/labthe	era) - continued	
assess equis O F	smen sites	it requ (tick b cribed	heumatoid arthritis - re-treatment in 'partial resp uired after 4 months poxes where appropriate) by, or recommended by a rheumatologist, or in acc	ponders' to rituximab cordance with a protocol or guideline that has been endorsed by the Health NZ
I	or	0 0 0	b infusions the patient had between a 30% and 50% decrease in active joint ponse to treatment in the opinion of the physician nab infusions the patient had at least a 50% decrease in active joint count to treatment in the opinion of the physician purses of rituximab infusions, the patient demonstrates at least a continuing ine and a clinically significant response to treatment in the opinion of the	
and and	Ο	Ritux	kimab re-treatment not to be given within 6 months of Rituximab to be used as an adjunct to methotrexat	
and		0	Patient is contraindicated to both methotrexate and	d leflunomide, requiring rituximab monotherapy to be used
and	0	Maxi	imum of two 1,000 mg infusions of rituximab given t	wo weeks apart
assess requis	smen sites	it requ (tick b cribed		s' to rituximab cordance with a protocol or guideline that has been endorsed by the Health NZ b infusions the patient had at least a 50% decrease in active joint count from
			baseline and a clinically significant response to tre	eatment in the opinion of the physician
	or	0		t courses of rituximab infusions, the patient demonstrates at least a continuing ine and a clinically significant response to treatment in the opinion of the
	0	O	30% improvement in active joint count from baseling	ine and a clinically significant response to treatment in the opinion of the
and	0	O Ritux	30% improvement in active joint count from baseling physician	of the previous course of treatment

RS1922 - Adalimumab (Humira - Alternative brand)

Arthritis - polyarticular course juvenile idiopathic - INITIATION	421
Arthritis - polyarticular course juvenile idiopathic - CONTINUATION	
Arthritis - psoriatic - INITIATION	
Arthritis - psoriatic - CONTINUATION	
Arthritis - oligoarticular course juvenile idiopathic - INITIATION	
Arthritis - oligoarticular course juvenile idiopathic - CONTINUATION	
Arthritis – rheumatoid - INITIATION	
Arthritis – rheumatoid - CONTINUATION	
Behcet's disease - severe - INITIATION	
Behcet's disease - severe - CONTINUATION	
Crohn's disease - adult - INITIATION	
Crohn's disease - adult - CONTINUATION	
Crohn's disease - children - INITIATION	
Crohn's disease - children - CONTINUATION	
Crohn's disease - fistulising - INITIATION	
Crohn's disease - fistulising - CONTINUATION	
Hidradenitis suppurativa - INITIATION	
Hidradenitis suppurativa - CONTINUATION	
Ocular inflammation - chronic - INITIATION	
Ocular inflammation – chronic - CONTINUATION	
Ocular inflammation – severe - INITIATION	
Ocular inflammation - severe - CONTINUATION	
Psoriasis - severe chronic plaque - INITIATION	
Psoriasis - severe chronic plaque - CONTINUATION	
Pyoderma gangrenosum - INITIATION	
Pyoderma gangrenosum - CONTINUATION	
Still's disease - adult-onset (AOSD) - INITIATION	
Still's disease - adult-onset (AOSD) - CONTINUATION	
Ankylosing spondylitis - INITIATION	
Ankylosing spondylitis - CONTINUATION	

PRESCRIBER	PATIENT:				
Name:	Name:				
Ward: NHI:					
Adalimumab (Humira - Alternative brand)					
	ccordance with a protocol or guideline that has been endorsed by the Health				
or	m adalimumab (Amgevita) following a minimum of 4 weeks treatment trol following a minimum of 4 weeks treatment with adalimumab esponse to a change in treatment regimen				
and O Patient has received a maximum of 6 months treatment with A and O Patient has previously had a Special Authority approval for the and O Adalimumab to be administered at doses no greater than 40 m	e Humira brand of adalimumab for this indication				
CONTINUATION – Behcet's disease – severe Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in an NZ Hospital. and	ccordance with a protocol or guideline that has been endorsed by the Health				
The patient has had a good clinical response to treatment with and Adalimumab to be administered at doses no greater than 40 r					
INITIATION – Hidradenitis suppurativa Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a dermatologist or Practitioner on the recommendation of a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.					
or O Patient has developed symptoms of loss of disease con (Amgevita) and clinician attributes this loss of disease read of the second disease read of the s	Amgevita				
 Patient has previously had a Special Authority approval for the and Adalimumab to be administered at doses no greater than 40 r 					

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:
Adalimumab (Humira - Alternative brand) - continued	
CONTINUATION – Hidradenitis suppurativa Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a dermatologist or Practitioner o or guideline that has been endorsed by the Health NZ Hospital.	n the recommendation of a dermatologist, or in accordance with a protocol
	ry nodules, abscesses, draining fistulae) of 25% or more from baseline
The patient has a Dermatology Quality of Life Index improvem	ent of 4 or more from baseline
O Adalimumab is to be administered at doses no greater than 40	Omg every 7 days. Fortnightly dosing has been considered
	n the recommendation of a dermatologist, or in accordance with a protocol
or guideline that has been endorsed by the Health NZ Hospital.	
or	n adalimumab (Amgevita) following a minimum of 4 weeks treatment trol following a minimum of 4 weeks treatment with adalimumab esponse to a change in treatment regimen
and O Patient has received a maximum of 6 months treatment with A and O	umgevita
Patient has previously had a Special Authority approval for the and	Humira brand of adalimumab for this indication
O Adalimumab to be administered at doses no greater than 40 n	a susani 14 deve

PRESCRIBER	R PATIENT:				
Name:	Name:				
Ward:	NHI:				
Adalimumab	ab (Humira - Alternative brand) - continued				
CONTINUATIO Re-assessment Prerequisites O Presc	ION – Psoriasis - severe chronic plaque ent required after 6 months (tick boxes where appropriate) escribed by, or recommended by a dermatologist or Practitioner on the recommendation of a dermatologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.	protocol			
	O Patient had "whole body" severe chronic plaque psoriasis at the start of treatment and O Following each prior adalimumab treatment course the patient has a PASI score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-adalimumab treatment baseline value O Following each prior adalimumab treatment course the patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, when compared with the pre-treatment baseline value				
or	And O Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment and O Following each prior adalimumab treatment course the patient has a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the treatment course baseline values O Following each prior adalimumab treatment course the patient has a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-adalimumab treatment baseline value				
and Adalimumab to be administered at doses no greater than 40 mg every 14 days INITIATION - Pyoderma gangrenosum Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ					
and Hospi	O The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatme	nt			
and ond	 Patient has received a maximum of 6 months treatment with Amgevita Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication A maximum of 8 doses 				

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 th	e Pharmaceutical
Schedule. For community funding, see the Special Authority Criteria.			

PRES	SCRIBER	ER PATIENT:	
Name:		Name:	
Ward	:	NHI:	
Adal	imuma	nab (Humira - Alternative brand) - continued	
Re-a	issessmei	ATION – Pyoderma gangrenosum nent required after 6 months tes (tick boxes where appropriate)	
Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Hospital.			
	and	The patient has demonstrated clinical improvement and continues to require treatment	
	\bigcup	A maximum of 8 doses]
INITIATION - Crohn's disease - adult Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance protocol or guideline that has been endorsed by the Health NZ Hospital.			dance with a
and		 or O The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treat and a maximum of 6 months treatment with Amgevita O Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment, and a maximum 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regime O Patient has Crohn's and is considered to be at risk of disease destabilisation if there were to be a change to current treatment treatment treatment attributes the other of the set of the set	m of nen
	and and	 Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication Adalimumab to be administered at doses no greater than 40 mg every 14 days 	
Re-a	issessmei	ATION – Crohn's disease - adult ment required after 6 months tes (tick boxes where appropriate)	
(and		rescribed by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accord rotocol or guideline that has been endorsed by the Health NZ Hospital.	dance with a
		O CDAI score has reduced by 100 points from the CDAI score when the patient was initiated on adalimumab O CDAI score is 150 or less	
		O The patient has demonstrated an adequate response to treatment, but CDAI score cannot be assessed	
	and	O Adalimumab to be administered at doses no greater than 40 mg every 14 days	

PRES	CRIE	BER		PATIENT:
Name	:			Name:
Ward:				NHI:
Adal	imu	mak	א (Hu	mira - Alternative brand) - continued
Re-a	ssess	smen	it requi	s disease - children red after 6 months oxes where appropriate)
				by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.
		or		The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita
		or		Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen
			0	Patient has Crohn's and is considered to be at risk of disease destabilisation if there were to be a change to current treatment
	and and	Ο	Patier	nt has previously had a Special Authority approval for the Humira brand of adalimumab for this indication
		Ο	Adalir	numab to be administered at doses no greater than 40 mg every 14 days
Prere (Эн	Presc proto	Cribed I col or c	by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital. PCDAI score has reduced by 10 points from the PCDAI score when the patient was initiated on adalimumab PCDAI score is 15 or less The patient has demonstrated an adequate response to treatment, but PCDAI score cannot be assessed numab to be administered at doses no greater than 40 mg every 14 days
Re-a	ssess	smen	it requi	red after 6 months oxes where appropriate)
(and	i C	Preso proto	ribed l col or (by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.
		or		The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita
		or		Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen
			\bigcirc	Patient has Crohn's and is considered to be at risk of disease destabilisation if there were to be a change to current treatment
	and and	Ο	Patier	nt has previously had a Special Authority approval for the Humira brand of adalimumab for this indication
		0	Adalir	numab to be administered at doses no greater than 40 mg every 14 days

PRES	CRIBEF	ł	PATIENT:
Name	:		
Ward:			NHI:
Adal	imuma	b (Hu	Imira - Alternative brand) - continued
Re-a	ssessme	ent requ	Crohn's disease - fistulising ired after 6 months poxes where appropriate)
and			by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.
	o	r 0	The number of open draining fistulae have decreased from baseline by at least 50% There has been a marked reduction in drainage of all fistula(e) from baseline as demonstrated by a reduction in the Fistula
	and	Adali	Assessment score, together with less induration and patient-reported pain mumab to be administered at doses no greater than 40 mg every 14 days
Re-a	ssessme	ent requ	r inflammation – chronic nired after 12 months poxes where appropriate)
and		scribed Hospita	by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health I.
	o	0	The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita. Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with Amgevita, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen
	0	0	Patient has uveitis and is considered to be at risk of vision loss if they were to change treatment
	and and		ent has previously had a Special Authority approval for the Humira brand of adalimumab for this indication mumab to be administered at doses no greater than 40 mg every 14 days
		Audii	Internability be administered at doses no greater than 40 mg every 14 days
Re-a	ssessme	ent requ	Dcular inflammation – chronic nired after 12 months poxes where appropriate)
and		scribed Hospita	by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health al.
	0	0	The patient has had a good clinical response following 12 weeks' initial treatment Following each 12-month treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema)
	and	Adali	Following each 12-month treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Adalimumab (Humira - Alternative brand) - continued	
INITIATION – Ocular inflammation – severe Re-assessment required after 12 months	
Prerequisites (tick boxes where appropriate)	
 Prescribed by, or recommended by any relevant practitioner, or in a NZ Hospital. and	ccordance with a protocol or guideline that has been endorsed by the Health
O The patient has experienced intolerable side effects fro and a maximum of 6 months treatment with Amgevita	m adalimumab (Amgevita) following a minimum of 4 weeks treatment,
O Patient has developed symptoms of loss of disease cor maximum of 6 months treatment with Amgevita and cli regimen	trol following a minimum of 4 weeks treatment with Amgevita, and a nician attributes this loss of disease response to a change in treatment
O Patient has uveitis and is considered to be at risk of visit	on loss if they were to change treatment
and O Patient has previously had a Special Authority approval for the	e Humira brand of adalimumab for this indication
Adalimumab to be administered at doses no greater than 40 m	ng every 14 days
CONTINUATION – Ocular inflammation – severe Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in a NZ Hospital.	ccordance with a protocol or guideline that has been endorsed by the Health
and O The patient has had a good clinical response following	3 initial doses
	has had a sustained reduction in inflammation (Standardisation of nber or vitreous cells, absence of active vitreous or retinal lesions, or
or	nas a sustained steroid sparing effect, allowing reduction in prednisone under 18 years old
Adalimumab to be administered at doses no greater than 40 m	ng every 14 days

PRESCRIBER	PATIENT:				
Name:	Name:				
Ward:	NHI:				
Adalimumab (Humira - Alternative brand) - continued					
INITIATION – ankylosing spondylitis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)					
O Prescribed by, or recommended by a rheumatologist or Practitioner protocol or guideline that has been endorsed by the Health NZ Hosp and	on the recommendation of a rheumatologist, or in accordance with a bital.				
O The patient has experienced intolerable side effects from	n adalimumab (Amgevita) following a minimum of 4 weeks treatment				
O Patient has developed symptoms of loss of disease con (Amgevita)	trol following a minimum of 4 weeks treatment with adalimumab				
and O Patient has received a maximum of 6 months treatment with A and	amgevita				
O Patient has previously had a Special Authority approval for the	e Humira brand of adalimumab for this indication				
Adalimumab to be administered at doses no greater than 40 n	ng every 14 days				
CONTINUATION – ankylosing spondylitis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a rheumatologist or Practitioner protocol or guideline that has been endorsed by the Health NZ Hosp and	on the recommendation of a rheumatologist, or in accordance with a pital.				
O Treatment has resulted in an improvement in BASDAI of 4 or improvement in BASDAI of 50%, whichever is less	more points from pre-treatment baseline on a 10 point scale, or an				
Adalimumab to be administered at doses no greater than 40 n	ng every 14 days				
INITIATION – Arthritis – oligoarticular course juvenile idiopathic Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)					
and	ogist, or in accordance with a protocol or guideline that has been endorsed				
or	n adalimumab (Amgevita) following a minimum of 4 weeks treatment trol following a minimum of 4 weeks treatment with adalimumab esponse to a change in treatment regimen				
and O Patient has received a maximum of 6 months treatment with A and O Patient has previously had a Special Authority approval for the					

Fori April	m RS1922 HOSPITAL MEDICINES LIST Page 42 2025 RESTRICTIONS CHECKLIST
	his 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 dule. For community funding, see the Special Authority Criteria.
PRES	SCRIBER PATIENT:
Name	e: Name:
Ward	: NHI:
Ada	limumab (Humira - Alternative brand) - continued
Re-a	ATINUATION – Arthritis – oligoarticular course juvenile idiopathic assessment required after 6 months requisites (tick box where appropriate)
and	O Prescribed by, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	O For patients that demonstrate at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline
Re-a	IATION – Arthritis - polyarticular course juvenile idiopathic assessment required after 6 months requisites (tick boxes where appropriate)
and	O Prescribed by, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	O The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment
	Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen
	O Patient has received a maximum of 6 months treatment with Amgevita
	O Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication
Re-a	ATINUATION – Arthritis - polyarticular course juvenile idiopathic assessment required after 6 months requisites (tick box where appropriate)
and	O Prescribed by, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	O For patients that demonstrate at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline
Re-a	IATION – Arthritis - psoriatic assessment required after 6 months requisites (tick boxes where appropriate)
and	O Prescribed by, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	O The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment or
	Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen

\mathbf{O}	Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication
\cup	Fallent has previously had a Special Autionity approval for the Furnita brand of adainfuthab for this indication

 $O\,$ Adalimumab to be administered at doses no greater than 40 mg every 14 days

I confirm that the above details are correct:

and

and

and

O Patient has received a maximum of 6 months treatment with Amgevita

PRESCRIBER						F	PATIENT:															
Name	:				••••			••••											Name:			
Ward					•••••			•••••												٨	JHI:	
Adal	imur	mab	(Hu	Jm	ira	ı -	Alt	er	na	tiv	e b	ora	nd)) - c	conti	inue	d					_
Re-a	TINU/ ssess equis	ment ites (t requ	uire cox	d a es '	fter whe	6 r ere	nor app	nths prop	oria				d	! _		- <i>u</i>		- 4 - 1			
and			Heal							<u></u>	ју а 			1 spe			JI 110	eum	aloi	<u> </u>	ist, or in accordance with a protocol or guideline that has been endorsed	
	(and	O The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a cli response to prior adalimumab treatment in the opinion of the treating physician																				
	(\mathbf{O}	Adali	imu	Ima	b t	o be	e a	dmi	nist	ere	d at	t dos	ses r	no g	great	ter th	nan 4	0 n	ng	every 14 days	J
Re-a	ATIOI ssess equis	ment	requ	uire	d a	fter	6 r	nor	nths		te)											
(and			escribed by, or recommended by a rheumatologist or Practitioner o btocol or guideline that has been endorsed by the Health NZ Hospi																			
		or	0 0	P	atie	nt	nas	de	velo	ope	d sy	ymp	otom	ns of	f los:	s of	dise	ase	con	itro	adalimumab (Amgevita) following a minimum of 4 weeks treatment of following a minimum of 4 weeks treatment with adalimumab ponse to a change in treatment regimen	
	and (and	0	Patie	ent	has	re	ceiv	/ed	ar	nax	imu	ım c	of 6	mon	nths	trea	atmei	nt wi	th A	۱m	gevita	
	(and	Ο	Patie	ent	has	pr	evio	ous	ly h	ad	a Si	pec	ial A	Autho	ority	y app	prova	al for	the	эH	lumira brand of adalimumab for this indication	
		or	0	A	dali	mu	ma	b to	o be	e ac	lmir	iiste	ered	at d	lose	es no	o gre	ater	tha	.n 4	40 mg every 14 days	
			0						tak esp			om	itant	t met	thot	trexa	ate a	nd re	equi	ire	s doses of adalimumab higher than 40 mg every 14 days to maintain	
Re-a	CONTINUATION – Arthritis – rheumatoid Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)																					
(and			ribed col or																		the recommendation of a rheumatologist, or in accordance with a al.	
	(and																				nt in active joint count from baseline and a clinically significant ating physician	
		or	0 0	P	atie	nt	can	not		ke c	onc						-				40 mg every 14 days s doses of adalimumab higher than 40 mg every 14 days to maintain	
				a	1 al		Jual		-sh											_		リ

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:				
Adalimumab	o (Humira - Alternative brand) - continued					
Re-assessment Prerequisites O Prese	Still's disease – adult-onset (AOSD) t required after 6 months (tick boxes where appropriate) cribed by, or recommended by a rheumatologist or Practitioner of col or guideline that has been endorsed by the Health NZ Hosp	on the recommendation of a rheumatologist, or in accordance with a ital.				
or	\mathbf{O}	n adalimumab (Amgevita) following a minimum of 4 weeks treatment trol following a minimum of 4 weeks treatment with adalimumab esponse to a change in treatment regimen				
and and	 Patient has received a maximum of 6 months treatment with Amgevita Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication 					
CONTINUATIO	N – Still's disease – adult-onset (AOSD)					

Re-assessment required after 6 months **Prerequisites** (tick box where appropriate)

and

O Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

The patient has demonstrated a sustained improvement in inflammatory markers and functional status

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.

PRES	SCR	RIBER	PATIENT:							
Name	e:		Name:							
Ward	:		NHI:							
Abci	Abciximab									
INITI Prer		ION uisites (tick boxes where appropriate)								
		O For use in patients with acute coronary syndromes undergoin	g percutaneous coronary intervention							
	or	O For use in patients undergoing intra-cranial intervention								

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:

Nivolumab

Re-a	INITIATION Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)									
(and		Presc Hospi	cribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.							
	and		Patient has metastatic or unresectable melanoma (excluding uveal) stage III or IV							
	and	Ο	Baseline measurement of overall tumour burden is documented clinically and radiologically							
	The patient has ECOG performance score of 0-2									
		or	O Patient has not received funded pembrolizumab							
			O Patient has received an initial Special Authority approval for pembrolizumab and has discontinued pembrolizumab within 12 weeks of starting treatment due to intolerance							
			The cancer did not progress while the patient was on pembrolizumab							
	and	Ο	Documentation confirming that the patient has been informed and acknowledges that funded treatment with nivolumab will not be continued if their disease progresses							
Re-a	ssess equis J F	smen sites	DN – less than 24 months on treatment t required after 4 months (tick boxes where appropriate) cribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.							
anu										
			O Patient's disease has had a complete response to treatment or _							
			O Patient's disease has had a partial response to treatment or							
			O Patient has stable disease							
		and	O Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period							
		and	$^{\tt u}O$ The treatment remains clinically appropriate and the patient is benefitting from the treatment							
	or									
		and	$\stackrel{O}{\rightharpoonup}$ Patient has previously discontinued treatment with nivolumab for reasons other than severe toxicity or disease progression d							
		and	O Patient has signs of disease progression							
			O Disease has not progressed during previous treatment with nivolumab							

PRES	CRIB	ER		PATIENT:
Name	:			
Ward:				NHI:
Nivol	uma	1b - c	continu	led
Re-as	ssessi equisi	ment i i tes (ti	require ick bo bed b	ore than 24 months on treatment ed after 4 months kes where appropriate) y, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and	(and			has been on treatment for more than 24 months O Patient's disease has had a complete response to treatment or O Patient's disease has had a partial response to treatment or
			and and	 O Patient has stable disease O Response to treatment in target lesions has been determined by comparable radiologic or clinical assessment following the most recent treatment period O The treatment remains clinically appropriate and the patient is benefitting from the treatment
		or	and and	 Patient has previously discontinued treatment with nivolumab for reasons other than severe toxicity or disease progression Patient has signs of disease progression Disease has not progressed during previous treatment with nivolumab

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:

Nivolumab - continued

or ()) Pa	atien	t is currently on treatment with nivolumab and met all remaining criteria prior to commencing treatment
	nd ()	The patient has metastatic renal cell carcinoma
)	The patient is treatment naive
	C)	The patient has ECOG performance status 0-2
	nd (nd)	The disease is predominantly of clear cell histology
			O The patient has sarcomatoid histology
		or	O Haemoglobin levels less than the lower limit of normal
		or	O Corrected serum calcium level greater than 10 mg/dL (2.5 mmol/L)
		or	O Neutrophils greater than the upper limit of normal
		or	O Platelets greater than the upper limit of normal
		or	O Interval of less than 1 year from original diagnosis to the start of systemic therapy
		or	O Karnofsky performance score of less than or equal to 70

INITIATION – renal cell carcinoma, second line Re-assessment required after 4 months

Prerequisites	(tick	boxes	where	appro	priate)

	Patient has metastatic renal-cell carcinoma
and	The disease is of predominant clear-cell histology
and	Patient has ECOG performance status 0-2
and	Patient has documented disease progression following one or two previous regimens of antiangiogenic therapy
and	
and	Patient has not previously received a funded immune checkpoint inhibitor
0	Nivolumab is to be used as monotherapy at a maximum dose of 240 mg every 2 weeks (or equivalent) and discontinued at disease progression

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	CRIBI	ER	PATIENT:	PATIENT:				
Name:			Name:	Name:				
Ward:			NHI:					
Nivol	uma	b -	continued					
Re-as	sessr	nent	N – renal cell carcinoma required after 4 months tick boxes where appropriate)					
		or or	 Patient's disease has had a complete response to treatment Patient's disease has had a partial response to treatment Patient has stable disease 					
	and and	С	No evidence of disease progression Nivolumab is to be used as monotherapy at a maximum dose of 240 mg every 2 weeks (or equivalent) and discontinue progression	ed at disease				

RS2056 - Pembrolizumab

MSI-H/dMMR advanced colorectal cancer - INITIATION	
MSI-H/dMMR advanced colorectal cancer - CONTINUATION	
Urothelial carcinoma - INITIATION	
Urothelial carcinoma - CONTINUATION	
Breast cancer, advanced - INITIATION	
Breast cancer, advanced - CONTINUATION	
Head and neck squamous cell carcinoma - INITIATION	
Head and neck squamous cell carcinoma - CONTINUATION	
Non-small cell lung cancer first-line combination therapy - INITIATION	
Non-small cell lung cancer first-line combination therapy - CONTINUATION	
Non-small cell lung cancer first-line monotherapy - INITIATION	
Non-small cell lung cancer first-line monotherapy - CONTINUATION	
Relapsed/refractory Hodgkin lymphoma - INITIATION	
Relapsed/refractory Hodgkin lymphoma - CONTINUATION	
Unresectable or metastatic melanoma - INITIATION	
Unresectable or metastatic melanoma, less than 24 months on treatment - CONTINUATION	
Unresectable or metastatic melanoma, more than 24 months on treatment - CONTINUATION .	

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:	

Pembrolizumab

INITIATION – unresectable or metastatic melanoma Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)						
(and	O Prescribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Hea Hospital.					
	and	0	Patient has metastatic or unresectable melanoma (excluding uveal) stage III or IV			
	and	Ο	Baseline measurement of overall tumour burden is documented clinically and radiologically			
	and	0	The patient has ECOG performance score of 0-2			
		or	O Patient has not received funded nivolumab			
			O Patient has received an initial Special Authority approval for nivolumab and has discontinued nivolumab within 12 weeks of starting treatment due to intolerance			
			and O The cancer did not progress while the patient was on nivolumab			
	and O Documentation confirming that the patient has been informed and acknowledges that funded treatment with pembrolizumab will not be continued if their disease progresses					
	Re-assessment required after 4 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.					
			O Patient's disease has had a complete response to treatment or			
			O Patient's disease has had a partial response to treatment			
		and	O Patient has stable disease			
			O Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period			
		and	O The treatment remains clinically appropriate and the patient is benefitting from the treatment			
	or		O Patient has previously discontinued treatment with pembrolizumab for reasons other than severe toxicity or disease progression			
		and				

Use this checklist to determine if a patient meets the restrictions for funding in the hospital setting	J. For more details, refer to Section H of the Pharmaceutical
Schedule. For community funding, see the Special Authority Criteria.	

PRESCRIB	ER		PATIENT:		
Name:					
Ward:			NHI:		
Pembroli	zum	ab - a	continued		
CONTINUATION – unresectable or metastatic melanoma, more than 24 months on treatment Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)					
	rescri lospita		, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ		
and (O Patient has been on treatment for more than 24 months				
			O Patient's disease has had a complete response to treatment or O Patient's disease has had a partial response to treatment or O Patient has stable disease		
		and (and	 Response to treatment in target lesions has been determined by comparable radiologic or clinical assessment following the most recent treatment period The treatment remains clinically appropriate and the patient is benefitting from the treatment 		
	or				
		(and (and	 Patient has previously discontinued treatment with pembrolizumab for reasons other than severe toxicity or disease progression Patient has signs of disease progression 		
		(D Disease has not progressed during previous treatment with pembrolizumab		

PRESCRIBER	PATIENT:				
Name:	Name:				
Ward:	NHI:				
Pembrolizumab - continued					
INITIATION – non-small cell lung cancer first-line monotherapy Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)					
O Prescribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.					
O Patient has locally advanced or metastatic, unresectable, non-	small cell lung cancer				
O Patient has not had chemotherapy for their disease in the palli	ative setting				
O Patient has not received prior funded treatment with an immur	ne checkpoint inhibitor for NSCLC				
O For patients with non-squamous histology there is documental EGFR or ALK tyrosine kinase unless not possible to ascertain	tion confirming that the disease does not express activating mutations of				
and O Pembrolizumab to be used as monotherapy and					
O There is documentation confirming the disease expresse validated test unless not possible to ascertain	es PD-L1 at a level greater than or equal to 50% as determined by a				
O There is documentation confirming the disease ex by a validated test unless not possible to ascertair	presses PD-L1 at a level greater than or equal to 1% as determined				
	interest of the patient based on clinician assessment				
and Patient has an ECOG 0-2					
O Pembrolizumab to be used at a maximum dose of 200 mg eve	ery three weeks (or equivalent) for a maximum of 16 weeks				
Baseline measurement of overall tumour burden is documente	ed clinically and radiologically				

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:	
Pembrolizu	mab - continued		
CONTINUATION – non-small cell lung cancer first-line monotherapy Re-assessment required after 4 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and			
or	O Patient's disease has had a partial response to treatmen		
and and and and	Response to treatment in target lesions has been determined by treatment period No evidence of disease progression	by comparable radiologic assessment following the most recent	
 The treatment remains clinically appropriate and patient is benefitting from treatment and Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent) and Treatment with pembrolizumab to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles every 3 weeks) 			
Re-assessmen Prerequisites O Pres	rdance with a protocol or guideline that has been endorsed by the Patient has locally advanced or metastatic, unresectable, non- The patient has not had chemotherapy for their disease in the Patient has not received prior funded treatment with an immuni	small cell lung cancer palliative setting e checkpoint inhibitor for NSCLC ion confirming that the disease does not express activating mutations of d chemotherapy ry three weeks (or equivalent) for a maximum of 16 weeks	

Form RS20 April 2025	56 HOSPITAL MEDICINES LIST Page 4 RESTRICTIONS CHECKLIST
	ist to determine if a patient meets the restrictions for funding in the hospital setting . For more details, refer to Section H of the Pharmaceutical community funding, see the Special Authority Criteria.
PRESCRIBER	PATIENT:
Name:	
Ward:	
Pembrolizu	mab - continued
Re-assessmen Prerequisites O Pres	DN – non-small cell lung cancer first-line combination therapy nt required after 4 months (tick boxes where appropriate) cribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in rdance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
and and and and and and and and	O Patient's disease has had a partial response to treatment
Re-assessmen Prerequisites O Pres	breast cancer, advanced ht required after 6 months (tick boxes where appropriate) cribed by, or recommended by a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in rdance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

(
		or	O Patient has recurrent or de novo unresectable, inoperable locally advanced triple-negative breast cancer (that does not express ER, PR or HER2 IHC3+ or ISH+ [including FISH or other technology])
			O Patient has recurrent or de novo metastatic triple-negative breast cancer (that does not express ER, PR or HER2 IHC3 or ISH+ [including FISH or other technology]
	and		
	(O Patient is treated with palliative intent	
and O Patient's cancer has confirmed PD-L1 Combined Positive Score (CPS) is greater than or equal to 10 and O Patient has received no prior systemic therapy in the palliative setting		Patient's cancer has confirmed PD-L1 Combined Positive Score (CPS) is greater than or equal to 10	
			and (
	and (С	Pembrolizumab is to be used in combination with chemotherapy
	and (С	Baseline measurement of overall tumour burden is documented clinically and radiologically
	and (\mathbf{O}	Pembrolizumab is to be used at a maximum dose of 200 mg every three weeks (or equivalent) for a maximum of 16 weeks

Signed: Date	:
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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		ER	PATIENT:	
Name:			Name:	
Ward	Ward: NHI:			
Pem	broli	zur	nab - continued	
Re-a	assess	men	DN – breast cancer, advanced trequired after 6 months (tick boxes where appropriate)	
and			cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.	
		or	O Patient's disease has had a complete response to treatment	
		or	O Patient's disease has had a partial response to treatment	
			O Patient has stable disease	
	and (and	С	No evidence of disease progression	
	and	С	Response to treatment in target lesions has been determined by a comparable radiologic assessment following the most recent treatment period	
	and (С	Pembrolizumab is to be used at a maximum dose of 200 mg every three weeks (or equivalent)	
	Treatment with pembrolizumab is to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks)			
INITIATION – head and neck squamous cell carcinoma Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)				
and	O Prescribed by, or recommended by a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
	(or	С	Patient is currently on treatment with pembrolizumab and met all remaining criteria prior to commencing treatment	
		an	O Patient has recurrent or metastatic head and neck squamous cell carcinoma of mucosal origin (excluding nasopharyngeal carcinoma) that is incurable by local therapies	
		an	O Patient has not received prior systemic therapy in the recurrent or metastatic setting	
			O Patient has a positive PD-L1 combined positive score (CPS) of greater than or equal to 1	
And O Patient has an ECOG performance score of 0-2		an	O Patient has an ECOG performance score of 0-2	
		un	O Pembrolizumab to be used in combination with platinum-based chemotherapy	
			or O Pembrolizumab to be used as monotherapy	
		an	d O Pembrolizumab is to be used at a maximum dose of 200 mg every three weeks (or equivalent) for a maximum of 16 weeks	

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:			
Vard: NHI:				
Pembrolizumab - continued				
CONTINUATION – head and neck squamous cell carcinoma Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)				
O Prescribed by, or recommended by any relevant practitioner, or in a NZ Hospital.	accordance with a protocol or guideline that has been endorsed by the Health			
O Patient's disease has had a complete response to treat or O Patient's disease has had a partial response to treatme or O Patient has stable disease				
and O No evidence of disease progression and O Pembrolizumab is to be used at a maximum dose of 200 mg every three weeks (or equivalent) and O Treatment with pembrolizumab is to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks)				
INITIATION – MSI-H/dMMR advanced colorectal cancer Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)				
O Prescribed by, or recommended by a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
O Patient is currently on treatment with pembrolizumab and me	t all remaining criteria prior to commencing treatment			
or	microsatellite instability-high (MSI-H) metastatic colorectal cancer microsatellite instability-high (MSI-H) unresectable colorectal cancer			
and O Patient is treated with palliative intent and O Patient has not previously received funded treatment w and O Patient has an ECOG performance score of 0-2 and O Baseline measurement of overall tumour burden is door				
Pembrolizumab to be used at a maximum dose of 200	mg every three weeks (or equivalent) for a maximum of 16 weeks			

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	BER PATIENT:		
Name:	Name:		
Ward: .	NHI:		
Pembr	lizumab - continued		
Re-ass	JATION – MSI-H/dMMR advanced colorectal cancer sment required after 4 months sites (tick boxes where appropriate) Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
and	 No evidence of disease progression Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent) 		
Re-ass	DN – Urothelial carcinoma sment required after 4 months sites (tick boxes where appropriate) Prescribed by, or recommended by a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in		
and	accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. O Patient is currently on treatment with pembrolizumab and met all remaining criteria prior to commencing treatment O Patient has inoperable locally advanced (T4) or metastatic urothelial carcinoma and O Patient has an ECOG performance score of 0-2		
	and O Patient has documented disease progression following treatment with chemotherapy and O Pembrolizumab to be used as monotherapy at a maximum dose of 200 mg every three weeks (or equivalent) for a maximum of 16 weeks		
CONTINUATION – Urothelial carcinoma Re-assessment required after 4 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
and	 No evidence of disease progression Pembrolizumab is to be used as monotherapy at a maximum dose of 200 mg every three weeks (or equivalent) 		

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:	

Pembrolizumab - continued

()

INITIATION – relapsed/refractory Hodgkin lymphoma Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)				
O Prescribed by, or recommended by a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
or Patient is currently on treatment with pembrolizumab and met all remaining criteria prior to commencing treatment				
O Patient has relapsed/refractory Hodgkin lymphoma after two or more lines of chemotherapy and O Patient is ineligible for autologous stem cell transplant				
or O Patient has relapsed/refractory Hodgkin lymphoma and has previously undergone an autologous stem cell transplant				
and O Patient has not previously received funded pembrolizumab and				
O Pembrolizumab to be administered at doses no greater than 200 mg once every 3 weeks				
CONTINUATION – relapsed/refractory Hodgkin lymphoma Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)				
O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
O Patient has received a partial or complete response to pembrolizumab				

Treatment with pembrolizumab is to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks)

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:
Durvalumab	

assess	men	Non-small cell lung cancer t required after 4 months (tick boxes where appropriate)
	or	O Patient has histologically or cytologically documented stage III, locally advanced, unresectable non-small cell lung cancer (NSCLC)
		O Patient has histologically or cytologically documented stage IIb (T1N2a only), locally advanced, unresectable non-small cell lung cancer (NSCLC)
and (0	Patient has received two or more cycles of platinum-based chemotherapy concurrently with definitive radiation therapy
and (О	Patient has no disease progression following the second or subsequent cycle of platinum-based chemotherapy with definitive radiation therapy treatment
and (and	О	Patient has a ECOG performance status of 0 or 1
and	О	Patient has completed last radiation dose within 8 weeks of starting treatment with durvalumab
and	Ο	Patient must not have received prior PD-1 or PD-L1 inhibitor therapy for this condition
	or	m O Durvalumab is to be used at a maximum dose of no greater than 10 mg/kg every 2 weeks
		O Durvalumab is to be used at a flat dose of 1500 mg every 4 weeks
and (0	Treatment with durvalumab to cease upon signs of disease progression
		DN – Non-small cell lung cancer t required after 4 months

Prerequisites (tick boxes where appropriate)

and	т C (The treatment remains clinically appropriate and the patient is benefitting from treatment O Durvalumab is to be used at a maximum dose of no greater than 10 mg/kg every 2 weeks
	or (O Durvalumab is to be used at a flat dose of 1500 mg every 4 weeks
and	_	
and	Г	Treatment with durvalumab to cease upon signs of disease progression
and	`	Treatment with durvalumab to cease upon signs of disease progression Total continuous treatment duration must not exceed 12 months
and	`	

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.

PRES	CRIBER	PATIENT:			
Name	e:	Name:			
Ward	ard: NHI:				
Atez	tezolizumab				
Re-a	ssessmer equisites O Prese	non-small cell lung cancer second line monotherapy th required after 4 months (tick boxes where appropriate) cribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in rdance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
	 Patient has locally advanced or metastatic non-small cell lung cancer and Patient has not received prior funded treatment with an immune checkpoint inhibitor for NSCLC and For patients with non-squamous histology there is documentation confirming that the disease does not express activating mutations of EGFR or ALK tyrosine kinase unless not possible to ascertain and Patient has an ECOG 0-2 and Patient has documented disease progression following treatment with at least two cycles of platinum-based chemotherapy Atezolizumab is to be used as monotherapy at a dose of 1200 mg every three weeks (or equivalent) for a maximum of 16 weeks Baseline measurement of overall tumour burden is documented clinically and radiologically 				
Re-a	ssessmer equisites O Prese	DN – non-small cell lung cancer second line monotherapy ht required after 4 months (tick boxes where appropriate) cribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in rdance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
	and and and and and and and	O Patient's disease has had a partial response to treatment			

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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:			

Atezolizumab - continued

	$\overline{\mathbf{O}}$	tick boxes where appropriate) Patient is currently on treatment with atezolizumab and met all remaining criteria prior to commencing treatment	
or		O Patient has locally advanced or metastatic, unresectable hepatocellular carcinoma	
	and	O Patient has preserved liver function (Child-Pugh A)	
	and	O Transarterial chemoembolisation (TACE) is unsuitable	
	and	O Patient has not received prior systemic therapy for the treatment of hepatocellular carcinoma	
		or O Patient received funded lenvatinib before 1 March 2025	
		O Patient has experienced treatment-limiting toxicity from treatment with lenvatinib	
		And O No disease progression since initiation of lenvatinib	
	and	\sim	
	and	\sim	
		O To be given in combination with bevacizumab	

Prerequisites (tick box where appropriate)

7

O No evidence of disease progression

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.

PRESCR	RIBER	PATIENT:		
Name:		Name:		
Ward:		NHI:		

Ipilimumab

or	Эт	he p	patient is currently on treatment with ipilimumab and met all remaining criteria prior to commencing treatment
	(С	The patient has metastatic renal cell carcinoma
	and (С	The patient is treatment naive
	and (С	The patient has ECOG performance status 0-2
	and (С	The disease is predominantly of clear cell histology
	and		O The patient has sarcomatoid histology
		or	O Haemoglobin levels less than the lower limit of normal
		or	O Corrected serum calcium level greater than 10 mg/dL (2.5 mmol/L)
		or	O Neutrophils greater than the upper limit of normal
		or	O Platelets greater than the upper limit of normal
		or	O Interval of less than 1 year from original diagnosis to the start of systemic therapy
		or	O Karnofsky performance score of less than or equal to 70

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.

PRESCRI	BER PATIENT:				
Name:	ame: Name:				
Ward:	/ard: NHI:				
Everolin	Everolimus				
Prerequis	sment required after 3 months sites (tick boxes where appropriate) Prescribed by, or recommended by a neurologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. O Patient has tuberous sclerosis				
Re-asses Prerequis	CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a neurologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Documented evidence of SEGA reduction or stabilisation by MRI within the last 3 months and O The treatment remains appropriate and the patient is benefiting from treatment and O Everolimus to be discontinued at progression of SEGAs				
Re-asses	VN – renal cell carcinoma sment required after 4 months sites (tick boxes where appropriate)				
or	 The patient has metastatic renal cell carcinoma and The disease is of predominant clear-cell histology and The patient has documented disease progression following one previous line of treatment and The patient has an ECOG performance status of 0-2 and Everolimus is to be used in combination with lenvatinib 				
	 Patient has received funded treatment with nivolumab for the second line treatment of metastatic renal cell carcinoma Patient has experienced treatment limiting toxicity from treatment with nivolumab Patient has experienced treatment limiting toxicity from treatment with nivolumab Everolimus is to be used in combination with lenvatinib There is no evidence of disease progression 				
Re-asses Prerequis	VATION – renal cell carcinoma sment required after 4 months sites (tick box where appropriate) There is no evidence of disease progression				

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.

RESCRIBER		PATIENT:
lame:		Name:
/ard:		NHI:
irolimus		
NITIATION Prerequisites (t	ick box where appropriate)	
Note: Rescue th	scue therapy for an organ transplant recipient erapy defined as unresponsive to calcineurin inhibi any of the following:	tor treatment as defined by refractory rejection; or intolerant to calcineurin inhibitor
• GFR < 30 ml	/min; or	
Rapidly progr	ressive transplant vasculopathy; or	
 Rapidly progr 	ressive obstructive bronchiolitis; or	
• HUS or TTP;	or	
Leukoencept	halopathy; or	
Significant m	alignant disease	
and or or and and	Patient has severe non-malignant lymphovascular n Malformations are not adequately controlled b Malformations are widespread/extensive and Sirolimus is to be used to reduce malformation Patient is being treated by a specialist lymphovascu Patient has measurable disease as defined by REC	by sclerotherapy and surgery sclerotherapy and surgery are not considered clinically appropriate In prior to consideration of surgery lar malformation multi-disciplinary team
Re-assessment	 I – severe non-malignant lymphovascular malfo required after 12 months ick boxes where appropriate) 	rmations*
or	according to RECIST version 1.1 (see Note)	esponse or a partial response to treatment, or patient has stable disease clinically and disease response to treatment has been clearly documents in
and	No evidence of progressive disease	
	The treatment remains clinically appropriate and the	patient is bonefitting from the treatment

1.1 (Eisenhauer et al. Eur J Cancer 2009;45:228-47) Indications marked with * are unapproved indications

Use this checklist to determine if a patient meets the restrictions for fundir Schedule. For community funding, see the Special Authority Criteria.	ng in the hospital setting . For more details, refer to Section H of the Pharmaceutical	
PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Sirolimus - continued		
INITIATION – renal angiomyolipoma(s) associated with tuberous so Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a nephrologist or urologist Health NZ Hospital. and O Patient has tuberous sclerosis complex*	clerosis complex*	
O Evidence of renal angiomyolipoma(s) measuring 3 cm o	or greater and that have shown interval growth	
and Demonstrated stabilisation or improvement in renal func	on or stability by magnetic resonance imaging (MRI) or ultrasound ction norrhage or significant adverse effects to sirolimus treatment	
Note: indications marked with are unapproved indications		
Hospital.	is complex*	
and O Patient has epilepsy with a background of documented t	tuberous sclerosis complex*	
O Vigabatrin has been trialled and has not added and has not added and O Seizures are not adequately controlled by, or treatment with at least two of the following: phenytoin sodium, and lacosamide (see Not or C) or O Vigabatrin is contraindicated and O Seizures are not adequately controlled by, or Seizures are not adequately controlled by a seizure are not adequately controlled by a seizu	or the patient has experienced unacceptable side effects from, optimal sodium valproate, topiramate, levetiracetam, carbamazepine, lamotrigine, te)	
benefit from mTOR inhibitor treatment prior to surgery	nappropriate for this patient, or the patient has been assessed and would sodium, sodium valproate, and topiramate. Those who can father children are not	

 \bigcirc

and

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	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Sirolimus - continued			
CONTINUATION – refractory seizures associated with tuberous sclerosis complex* Re-assessment required after 12 months			

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

Demonstrated significant and sustained improvement in seizure rate (e.g. 50% reduction in seizure frequency) or severity and/or patient quality of life compared with baseline prior to starting sirolimus treatment Note: Indications marked with * are unapproved indications

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:
Bacillus calmette-guerin (BCG)	
INITIATION Prerequisites (tick box where appropriate)	
O For use in bladder cancer	

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:

Upadacitinib

Re-a	INITIATION – Rheumatoid Arthritis (patients previously treated with adalimumab or etanercept) Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)						
and			rescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ lospital.				
	and	0	The p	atient has had an initial Special Authority approval for adalimumab and/or etanercept for rheumatoid arthritis			
		or	or O The patient has experienced intolerable side effects from adalimumab and/or etanercept O The patient has received insufficient benefit from at least a three-month trial of adalimumab and/or etanercept such that they do not meet the renewal criteria for rheumatoid arthritis				
	and	d or O The patient is seronegative for both anti-cyclic citrullinated peptide (CCP) antibodies and rheumatoid factor O The patient has been started on rituximab for rheumatoid arthritis in a Health NZ Hospital					
			and	O The patient has experienced intolerable side effects from rituximab or O At four months following the initial course of rituximab the patient has received insufficient benefit such that they do not meet the renewal criteria for rheumatoid arthritis			

CONTINUATION – Rheumatoid Arthritis

Re-assessment required after 6 months **Prerequisites** (tick boxes where appropriate)

()

or

rerequisites (lick boxes where appropriate)

\cup	Prescribed by, or recommended by a rheum	atologist, or	r in accordance with	a protocol or guideline th	at has been endorsed by the H	ealth NZ
	Hospital.					
and						

Following 6 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician

On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician

Respiratory System and Allergies

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.

PRES	CR	IBER		PATIENT:
Name	:			Name:
Ward:				NHI:
Icatil	bar	nt		
	sses	ssmen isites Presc	t required after 12 months (tick boxes where appropriate) ribed by, or recommended by a clinical immunologist or relevar rsed by the Health NZ Hospital.	nt specialist, or in accordance with a protocol or guideline that has been
	an		Supply for anticipated emergency treatment of laryngeal/oro-p (HAE) for patients with confirmed diagnosis of C1-esterase inh	haryngeal or severe abdominal attacks of acute hereditary angioedema ibitor deficiency
		Ο	The patient has undergone product training and has agreed upon an action plan for self-administration	

CONTINUATION

Re-assessment required after 12 months Prerequisites (tick box where appropriate)

O The treatment remains appropriate and the patient is benefiting from treatment

or

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	PATIENT:
Name:	Name:
Ward:	NHI:
Adrenaline	
INITIATION – anaphylaxis Prerequisites (tick boxes where appropriate)	
O Patient has experienced a previous anaphylactic reaction which	ch has resulted in presentation to a hospital or emergency department

Patient has been assessed to be at significant risk of anaphylaxis by a relevant practitioner

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:
Bee venom	
INITIATION Prerequisites (tick boxes where appropriate)	
ARAST or skin test positive	
O Patient has had severe generalised reaction to the sensitisir	g agent

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.

PRES	SCRIBER		PATIENT:
Name	:		Name:
Ward:	:		NHI:
Раре	er wasp	venom	
	ATION equisites	(tick boxes where appropriate)	
	and	RAST or skin test positive	
	Ö	Patient has had severe generalised reaction to the sensitising	agent

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:
Yellow jacket wasp venom	
INITIATION Prerequisites (tick boxes where appropriate)	
ARAST or skin test positive	
O Patient has had severe generalised reaction to the sensit	ising agent

Form	RS1518
April 20	25

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:

Long-acting muscarinic antagonists with long-acting beta-adrenoceptor agonists

INITIATION Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)	
O Patient has been stabilised on a long acting muscarinic antagonist	
The prescriber considers that the patient would receive additional benefit from switching to a combination product	
CONTINUATION Re-assessment required after 2 years	
Prerequisites (tick boxes where appropriate)	
O Patient is compliant with the medication	
O Patient has experienced improved COPD symptom control (prescriber determined)	J

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:		

Fluticasone furoate with umeclidinium and vilanterol

	Patient is currently receiving an inhaled corticosteroid with long acting beta-2 agonist (ICS/LABA) or a long acting muscarinic antagonist with long acting beta-2 agonist (LAMA/LABA)
and	Clinical criteria:
	O Patient has a COPD Assessment Test (CAT) score greater than 10
	or O Patient has had 2 or more exacerbations in the previous 12 months
or O Patient has had one exacerbation requiring hospitalisation in the previous 12 months or	
	O Patient has had an eosinophil count greater than or equal to 0.3 × 10 [°] 9 cells/L in the previous 12 months
	and

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:		

Budesonide with glycopyrronium and eformoterol

and		sible
		O Patient is currently receiving an inhaled corticosteroid with long acting beta-2 agonist (ICS/LABA) or a long acting muscarinic antagonist with long acting beta-2 agonist (LAMA/LABA)
	a	Clinical criteria:
		O Patient has a COPD Assessment Test (CAT) score greater than 10
		O Patient has had 2 or more exacerbations in the previous 12 months
	O Patient has had one exacerbation requiring hospitalisation in the previous 12 months	
		or O Patient has had an eosinophil count greater than or equal to 0.3 × 10 [°] 9 cells/L in the previous 12 months
	or	

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:		

Pirfenidone

			diopathic pulmonary fibrosis		
	Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)				
(and			bribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.		
	(С	Patient has been diagnosed with idiopathic pulmonary fibrosis by a multidisciplinary team including a radiologist		
	and (and	С	Forced vital capacity is between 50% and 90% predicted		
	and	С	Pirfenidone is to be discontinued at disease progression (See Notes)		
	and (С	Pirfenidone is not to be used in combination with subsidised nintedanib		
			O The patient has not previously received treatment with nintedanib		
		or or	O Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance		
			O Patient has previously received nintedanib, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with nintedanib)		
CONTINUATION – idiopathic pulmonary fibrosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)					
(and			ribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.		
	(and	С	Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment		
	and (С	Pirfenidone is not to be used in combination with subsidised nintedanib		
	and (С	Pirfenidone is to be discontinued at disease progression (See Note)		

Note: disease progression is defined as a decline in percent predicted FVC of 10% or more within any 12 month period.

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:

Nintedanib

Re-a	ssess	N – idiopathic pulmonary fibrosis sment required after 12 months sites (tick boxes where appropriate)
(and		Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	(and	O Patient has been diagnosed with idiopathic pulmonary fibrosis by a multidisciplinary team including a radiologist
	(and	O Forced vital capacity is between 50% and 90% predicted
	(and	\sim
	and	
		O The patient has not previously received treatment with pirfenidone or
		 Patient has previously received pirfenidone, but discontinued pirfenidone within 12 weeks due to intolerance Or Patient has previously received pirfenidone, but the patient's disease has not progressed (disease progression defined as 10%)
		or more decline in predicted FVC within any 12 month period since starting treatment with pirfenidone)
Re-a	ssess	ATION – idiopathic pulmonary fibrosis sment required after 12 months sites (tick boxes where appropriate)
(and		Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	(and	O Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment
	(and	O Nintedanib is not to be used in combination with subsidised pirfenidone
	(O Nintedanib is to be discontinued at disease progression (See Note)

Note: disease progression is defined as a decline in percent predicted FVC of 10% or more within any 12 month period.

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	CRIBE	ER		PATIENT:
Name:				
Ward:				NHI:
Ivaca	ftor			
INITIA Prerect	quisit	t es (resc	ribed	boxes where appropriate) by, or recommended by a respiratory specialist or paediatrician, or in accordance with a protocol or guideline that has been by the Health NZ Hospital.
	O Patient has been diagnosed with cystic fibrosis			
		or	0	Patient must have G551D mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene on at least 1 allele
		01	0	Patient must have other gating (class III) mutation (G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N and S549R) in the CFTR gene on at least 1 allele
	and			ents must have a sweat chloride value of at least 60 mmol/L by quantitative pilocarpine iontophoresis or by Macroduct sweat ction system
	and (and)	Treat	tment with ivacaftor must be given concomitantly with standard therapy for this condition
${ m O}$ Patient must not have an acute upper or lower respiratory infection, pulmonary exact				ent must not have an acute upper or lower respiratory infection, pulmonary exacerbation, or changes in therapy (including iotics) for pulmonary disease in the last 4 weeks prior to commencing treatment with ivacaftor
	and (and	C	The c	dose of ivacaftor will not exceed one tablet or one sachet twice daily
)	Appli	icant has experience and expertise in the management of cystic fibrosis

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:		

Elexacaftor with tezacaftor, ivacaftor and ivacaftor

INITIATION

equisi	ites	(tick b	poxes where appropriate)
(and	С	Patie	ent has been diagnosed with cystic fibrosis
and (С	Patie	ent is 6 years of age or older
		Ο	Patient has two cystic fibrosis-causing mutations in the cystic fibrosis transmembrane regulator (CFTR) gene (one from each parental allele)
	or	0	Patient has a sweat chloride value of at least 60 mmol/L by quantitative pilocarpine iontophoresis or by Macroduct sweat collection system
and	_		
		Ο	Patient has a heterozygous or homozygous F508del mutation
	or	Ο	Patient has a G551D mutation or other mutation responsive in vitro to elexacaftor/tezacaftor/ivacaftor (see note a)
and (С	The t	treatment must be the sole funded CFTR modulator therapy for this condition
and (С	Treat	ment with elexacaftor/tezacaftor/ivacaftor must be given concomitantly with standard therapy for this condition
			s are listed in the Food and Drug Administration (FDA) Trikafta prescribing information a.gov/fdalabel/services/spl/set-ids/f354423a-85c2-41c3-a9db-0f3aee135d8d/spl-doc

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:		

Dornase alfa

INITIATION – cystic fibrosis Re-assessment required after 12 months			
Prerequisites (tick boxes where appropriate)			
O 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.			
O Patient has a confirmed diagnosis of cystic fibrosis			
O Patient has previously undergone a trial with, or is currently being treated with, hypertonic saline and			
O Patient has required one or more hospital inpatient respiratory admissions in the previous 12 month period or			
O Patient has had 3 exacerbations due to CF, requiring oral or intravenous (IV) antibiotics in in the previous 12 month period or			
O Patient has had 1 exacerbation due to CF, requiring oral or IV antibiotics in the previous 12 month period and a Brasfield score of $< 22/25$			
O Patient has a diagnosis of allergic bronchopulmonary aspergillosis (ABPA)			
CONTINUATION – cystic fibrosis Prerequisites (tick box where appropriate) O 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 O 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)			
A 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)			
O Patient is an in-patient			
O Patient diagnoses with pleural emphyema			

Sensory Organs

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:

Dexamethasone

INITIATION – Diabetic macular oedema		
Re-assessment required after 12 months		
Prerequisites (tick boxes where appropriate)		
O Prescribed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
O Patients have diabetic macular oedema with pseudophakic lens		
O Patient has reduced visual acuity of between 6/9 – 6/48 with functional awareness of reduction in vision and		
O Patient's disease has progressed despite 3 injections with bevacizumab or		
O Patient is unsuitable or contraindicated to treatment with anti-VEGF agents		
Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year		
CONTINUATION – Diabetic macular oedema Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)		
O Prescribed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
O Patient's vision is stable or has improved (prescriber determined)		
O Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year		
INITIATION – Women of child bearing age with diabetic macular oedema Re-assessment required after 12 months		
Prerequisites (tick boxes where appropriate)		
O Prescribed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
Patients have diabetic macular oedema		
O Patient has reduced visual acuity of between 6/9 – 6/48 with functional awareness of reduction in vision and		
O Patient is of child bearing potential and has not yet completed a family and		
O Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year		

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.

PRES	SCRIB	ER	PATIENT:
Name	:		Name:
Ward	:		NHI:
Dexamethasone - continued			
CONTINUATION – Women of child bearing age with diabetic macular oedema Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and			
Patient's vision is stable or has improved (prescriber determined) and Patient is of child bearing potential and has not yet completed a family and			
	(Dexamethasone implants are to be administered not more free of 3 implants per eye per year	quently than once every 4 months into each eye, and up to a maximum

Various

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:

Deferasirox

2010					
INITIATION Re-assessment required after 2 years 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 N2 Hospital.					
	and	O Deferasirox is to be given at a daily dose not exceeding 40 mg/kg/day or or O Treatment with maximum tolerated doses of deferiprone monotherapy or deferiprone and desferrioxamine combination therapy have proven ineffective as measured by serum ferritin levels, liver or cardiac MRI T2* O Treatment with deferiprone has resulted in severe persistent vomiting or diarrhoea			
		or O Treatment with deferiprone has resulted in arthritis or O Treatment with deferiprone is contraindicated due to a history of agranulocytosis (defined as an absolute neutrophil count (ANC) of < 0.5 cells per μL) or recurrent episodes (greater than 2 episodes) of moderate neutropenia (ANC 0.5 - 1.0 cells per μL)			
CONTINUATION Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)					
and	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.				
	or	 For the first renewal following 2 years of therapy, the treatment has been tolerated and has resulted in clinical improvement in all three parameters namely serum ferritin, cardiac MRI T2* and liver MRI T2* levels For subsequent renewals, the treatment has been tolerated and has resulted in clinical stability or continued improvement in all three parameters namely serum ferritin, cardiac MRI T2* and liver MRI T2* levels. 			

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:		
Deferiprone			
INITIATION			

Prerequisites (tick box where appropriate)

O Patient has been diagnosed with chronic iron overload due to congenital inherited anaemia or acquired red cell aplasia

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:
Povidone-iodine - Vaginal tab 200 mg	
Prerequisites (tick box where appropriate)	
O Rectal administration pre-prostate biopsy	

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:	
Chlorhexidine with cetrimide		
Chlorhexidine with cetrimide INITIATION Re-assessment required after 3 months Prerequisites (tick boxes where appropriate) O Patient has burns that are greater than 30% of total body surface area (BSA) and O For use in the perioperative preparation and cleansing of large burn areas requiring debridement/skin grafting O The use of 30 ml ampoules is impractical due to the size of the area to be covered		
CONTINUATION		

Re-assessment required after 3 months Prerequisites (tick box where appropriate)

O The treatment remains appropriate for the patient and the patient is benefiting from the treatment

Special Foods

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:	

Carbohydrate

INITIATION – Use as an additive Prerequisites (tick boxes where appropriate)				
Ο	Cystic fibrosis			
or O	Chronic kidney disease			
or O	Cancer in children			
or O	Cancers affecting alimentary tract where there are malabsorption problems in patients over the age of 20 years			
or O	Faltering growth in an infant/child			
or O	Bronchopulmonary dysplasia			
or O	Premature and post premature infant			
or O	Inborn errors of metabolism			
INITIATION – Use as a module				

Prerequisites (tick box where appropriate)

O For use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

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.

PRES	CRI	BER	PATIENT:	
Name	:			••
Ward			NHI:	
Fat				
			Ise as an additive (tick boxes where appropriate)	
		0	Patient has inborn errors of metabolism	
	or or	Ο	Faltering growth in an infant/child	
	or	Ο	Bronchopulmonary dysplasia	
	or	Ο	Fat malabsorption	
	or	Ο	Lymphangiectasia	
	or	0	Short bowel syndrome	
	or	0	Infants with necrotising enterocolitis	
	or	0	Biliary atresia	
	or	0	For use in a ketogenic diet	
	or	0	Chyle leak	
	or	0	Ascites	
		Ο	Patient has increased energy requirements, and for whom dietary measures have not been successful	

INITIATION – Use as a module

Prerequisites (tick box where appropriate)

O For use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk. Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Protein	
INITIATION – Use as an additive Prerequisites (tick boxes where appropriate)	
or High protein needs	
INITIATION – Use as a module	

Prerequisites (tick box where appropriate)

O For use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk. Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

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:		
Carbohydrate and fat supplement			

Carbonydrate and fat supplement

ATION equisi		tick b	poxes where appropriate)
(and	С	Infan	t or child aged four years or under
	or	Ο	Cystic fibrosis
	or	Ο	Cancer in children
	or	Ο	Faltering growth
	or	Ο	Bronchopulmonary dysplasia
		Ο	Premature and post premature infants

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.

PRES	SCR	IBER	PATIENT:
Name	e:		Name:
Ward:	:		NHI:
Meta	bo	lic Products	
INITIATION Prerequisites (tick boxes where appropriate)			
		O For the dietary management of inherited metabolic disease	
	or	O Patient has adrenoleukodystrophy	

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:

Diabetic Products

INITI Prere			(tick boxes where appropriate)
		Ο	For patients with type I or type II diabetes suffering weight loss and malnutrition that requires nutritional support
	or	Ο	For patients with pancreatic insufficiency
	or O For patients who have, or are expected to, eat little or nothing for 5 days		For patients who have, or are expected to, eat little or nothing for 5 days
	For patients who have a poor absorptive capacity and/or high nutrient losses and/or increased nutritional needs from causes such as catabolism		
	or	0	For use pre- and post-surgery
	or	Ο	For patients being tube-fed
	or	0	For tube-feeding as a transition from intravenous nutrition

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:			
Elemental and Semi-Elemental Products				
)			

NITIAT Prerequ		(tick boxes where appropriate)	
o	r O	Malabsorption Short bowel syndrome	
o	r O	Enterocutaneous fistulas	
0	Ο	Eosinophilic enteritis (including oesophagitis)	
0	Ο	Inflammatory bowel disease	
0	Ο	Acute pancreatitis where standard feeds are not tolerated	
	Ο	Patients with multiple food allergies requiring enteral feeding	

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:
Fat-modified feed	
INITIATION Prerequisites (tick boxes where appropriate) O Patient has metabolic disorders of fat metabolism or O or O Modified as a modular feed, made from at least one nutrient r Pharmaceutical Schedule, for adults	nodule and at least one further product listed in Section D of the

Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

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:
Hepatic Products	
INITIATION Prerequisites (tick box where appropriate)	
O For children (up to 18 years) who require a liver transplant	

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:
High Calorie Products	

INITIATION

or	Ор	ient is fluid volume or rate restricted	
or	Ор	ient requires low electrolyte	
		O Cystic fibrosis	
		O Any condition causing malabsorption	
		 Faltering growth in an infant/child Increased nutritional requirements 	
	and		

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	CRIB	ER			PATIENT:
Name:					Name:
Ward:					NHI:
High	prot	tein	ent	eral feed	
	quisi (poxes where appropriate) patient has a high protein requirement	
	and	or or or	0 0 0	Patient has liver disease Patient is obese (BMI > 30) and is undergoing surgery Patient is fluid restricted	

O Patient's needs cannot be more appropriately met using high calorie product

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:		

Extensively hydrolysed formula

INITIATION Prerequisites (tick boxes where appropriate) Cows' milk formula is inappropriate due to severe intolerance or allergy to its protein content and Soy milk formula has been reasonably trialled without resolution of symptoms or Soy milk formula is considered clinically inappropriate or contraindicated or () Severe malabsorption or Short bowel syndrome or Intractable diarrhoea or Biliary atresia or Cholestatic liver diseases causing malsorption or Cystic fibrosis or () Proven fat malabsorption or Severe intestinal motility disorders causing significant malabsorption or ()Intestinal failure or For step down from Amino Acid Formula Note: A reasonable trial is defined as a 2-4 week trial, or signs of an immediate IgE mediated allergic reaction. CONTINUATION

Prerequisites (tick boxes where appropriate)

 \bigcirc

and

An assessment as to whether the infant can be transitioned to a cows' milk protein or soy infant formula has been undertaken

The outcome of the assessment is that the infant continues to require an extensively hydrolysed infant formula

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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Preterm formula	
INITIATION Prerequisites (tick box where appropriate)	
O For infants born before 33 weeks' gestation or weighing less than 1.	5 kg at birth

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:	
Paediatric oral/enteral feed 1 kcal/ml		
INITIATION – Fluid restricted or volume intolerance with faltering growth		

Prerequisites (tick boxes where appropriate)

or

and

The patient is fluid restricted or volume intolerant

The patient has increased nutritional requirements due to faltering growth ()

) Patient is under 18 months old and weighs less than 8kg

Note: 'Volume intolerant' patients are those who are unable to tolerate an adequate volume of infant formula to achieve expected growth rate. These patients should have first trialled appropriate clinical alternative treatments, such as concentrating, fortifying and adjusting the frequency of feeding.

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:	

Enteral liquid peptide formula

INITIATION Prerequisites (tick boxes where appropriate) () Patient has impaired gastrointestinal function and either cannot tolerate polymeric feeds, or polymeric feeds are unsuitable and () Severe malabsorption or Short bowel syndrome or Intractable diarrhoea or Biliary atresia or Cholestatic liver diseases causing malabsorption or Cystic fibrosis or Proven fat malabsorption or Severe intestinal motility disorders causing significant malabsorption or Intestinal failure or O The patient is currently receiving funded amino acid formula and The patient is to be trialled on, or transitioned to, an enteral liquid peptide formula and () A semi-elemental or partially hydrolysed powdered feed has been reasonably trialled and considered unsuitable or For step down from intravenous nutrition Note: A reasonable trial is defined as a 2-4 week trial. CONTINUATION Prerequisites (tick boxes where appropriate) An assessment as to whether the patient can be transitioned to a cows milk protein or soy infant formula or extensively hydrolysed formula has been undertaken and

The outcome of the assessment is that the patient continues to require an enteral liquid peptide formula

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.

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		

Amino acid formula

INITIATION Prerequisites (tick boxes where appropriate) O Extensively hydrolysed formula has been reasonably trialled for 2-4 weeks and is inappropriate due to documented severe intolerance or allergy or malabsorption O History of anaphylaxis to cows' milk protein formula or dairy products Or O Eosinophilic oesophagitis Or O Ultra-short gut O Severe Immune deficiency

CONTINUATION

and

and

and

and

Prerequisites	(tick boxes where	appropriate)
---------------	-------------------	--------------

An assessment as to whether the infant can be transitioned to a cows' milk protein, soy, or extensively hydrolysed infant formula has been undertaken
 The outcome of the assessment is that the infant continues to require an amino acid infant formula

 \bigcirc Amino acid formula is required for a nutritional deficit

INITIATION - patients who are currently funded under RS1502 or SA1557

Re-assessment required after 3 months **Prerequisites** (tick boxes where appropriate)

Patient has a valid initiation or renewal approval for extensively hydrolysed formula (RS1502)

Patient is unable to source funded Aptamil powder at this time

The approval only applies to funded dispensings of Neocate Gold and Neocate Syneo

Note: This criteria is short term funding to cover an out-of-stock situation on some extensively hydrolysed formula powder funded under Hospital Restriction RS1502. There is no continuation criteria under this criterion.

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.

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
High fat formula			

INITIATION

Prerequisites (tick box where appropriate)

()For patients with intractable epilepsy, pyruvate dehydrogenase deficiency or glucose transported type-1 deficiency and other conditions requiring a ketogenic diet

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:

Paediatric Products

ITIATIC erequi		(tick b	poxes where appropriate)
and	O	Chilc	d is aged one to ten years
	or	Ο	The child is being fed via a tube or a tube is to be inserted for the purposes of feeding
	-	Ο	Any condition causing malabsorption
	or	Ο	Faltering growth in an infant/child
	or	Ο	Increased nutritional requirements
	or	Ο	The child is being transitioned from TPN or tube feeding to oral feeding
	or	Ο	The child has eaten, or is expected to eat, little or nothing for 3 days
	\subseteq		

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:
Low electrolyte oral feed	
INITIATION Prerequisites (tick box where appropriate)	
O For children (up to 18 years) with acute or chronic kidney disease	

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:
Low electrolyte oral feed	
INITIATION Prerequisites (tick box where appropriate)	
O For patients with acute or chronic kidney disease	

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:	
Preoperative carbohydrate feed 0.5 kcal/ml		

INITIATION

Prerequisites (tick box where appropriate)

O Maximum of 400 ml as part of an Enhanced Recovery After Surgery (ERAS) protocol 2 to 3 hours before major abdominal surgery

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:	
High arginine oral feed 1.4 kcal/ml		
INITIATION Prerequisites (tick box where appropriate)		
m O Three packs per day for 5 to 7 days prior to major gastrointestinal, h	ead or neck surgery	

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:
Standard Feeds	

INITIATION

	For	patients with malnutrition, defined as any of the following:
		O BMI < 18.5
	or	O Greater than 10% weight loss in the last 3-6 months
		O BMI < 20 with greater than 5% weight loss in the last 3-6 months
or	~	
	\bigcirc	For patients who have, or are expected to, eat little or nothing for 5 days
or or	0	For patients who have a poor absorptive capacity and/or high nutrient losses and/or increased nutritional needs from causes such as catabolism
01	Ο	For use pre- and post-surgery
or	0	For patients being tube-fed
or	Ο	For tube-feeding as a transition from intravenous nutrition
or	\cap	For any other condition that meets the community Special Authority criteria

Vaccines

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:

Diphtheria, tetanus, pertussis and polio vaccine

	Ο	A single dose for children up to the age of 7 who have completed primary immunisation
or	Ο	A course of up to four vaccines is funded for catch up programmes for children (to the age of 10 years) to complete full primary
or	2	immunisation
	Ο	An additional four doses (as appropriate) are funded for (re-)immunisation for patients post HSCT, or chemotherapy; pre- or post
or	-	splenectomy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens
	\bigcirc	Five doses will be funded for children requiring solid organ transplantation

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:	

Diphtheria, tetanus, pertussis, polio, hepatitis B and haemophilus influenzae type B vaccine

O Up to four doses for children under the age of 10 years for primary immunisation or O An additional four doses (as appropriate) for (re-)immunisation of children under the age of 18 years post haematopoietic stem cell transplantation or O An additional four doses (as appropriate) for (re-)immunisation of children under the age of 10 years who are post chemotherapy; pre or post splenectomy; undergoing renal dialysis and other severely immunosuppressive regimens or O Up to five doses for children under the age of 10 years receiving solid organ transplantation	INITIATION Prerequisites (tick boxes where appropriate)			
 An additional four doses (as appropriate) for (re-)immunisation of children under the age of 18 years post haematopoietic stem cell transplantation An additional four doses (as appropriate) for (re-)immunisation of children under the age of 10 years who are post chemotherapy; pre or post splenectomy; undergoing renal dialysis and other severely immunosuppressive regimens 			0	Up to four doses for children under the age of 10 years for primary immunisation
O An additional four doses (as appropriate) for (re-)immunisation of children under the age of 10 years who are post chemotherapy; pre or post splenectomy; undergoing renal dialysis and other severely immunosuppressive regimens			0	
$\mathbf{\hat{c}}$			0	
		or	0	Up to five doses for children under the age of 10 years receiving solid organ transplantation

Note: A course of up-to four vaccines is funded for catch up programmes for children (up to and under the age of 10 years) to complete full primary immunisation. Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes.

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:
Baci	llus cal	mette-guerin vaccine	
INITIATION Prerequisites (tick boxes where appropriate)			
For infants at increased risk of tuberculosis defined as: O Living in a house or family with a person with current or past history of TB and O Having one or more household members or carers who within the last 5 years lived in a country			
	and	100,000 for 6 months or longer During their first 5 years will be living 3 months or longer in a c	

Note: A list of countries with high rates of TB are available at http://www.health.govt.nz/tuberculosis (Search for Downloads) or www.bcgatlas.org/index.php

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:

Diphtheria, tetanus and pertussis vaccine

INITIATION Prerequisites (tick boxes where appropriate) () A single dose for pregnant women in the second or third trimester of each pregnancy; or or A single dose for parents or primary caregivers of infants admitted to a Neonatal Intensive Care Unit or Specialist Care Baby Unit for more than 3 days, who had not been exposed to maternal vaccination at least 14 days prior to birth; or or A course of up to four doses is funded for children from age 7 up the age of 18 years inclusive to complete full primary immunisation or An additional four doses (as appropriate) are funded for (re-)immunisation for patients post haematopoietic stem cell transplantation or chemotherapy; pre or post splenectomy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens or A single dose for vaccination of patients aged from 65 years old or A single dose for vaccination of patients aged from 45 years old who have not had 4 previous tetanus doses or For vaccination of previously unimmunised or partially immunised patients or For revaccination following immunosuppression or For boosting of patients with tetanus-prone wounds

Note: Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes.

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	1	PATIENT:
Name:		Name:
Ward:		NHI:
Haemophil	us influenzae type B vaccine	
	chemotherapy; functional asplenic; pre or post splenectomy; p dialysis and other severely immunosuppressive regimens	ation for patients post haematopoietic stem cell transplantation, or rre- or post solid organ transplant, pre- or post cochlear implants, renal the recommendation of an internal medicine physician or paediatrician

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:

Meningococcal (A, C, Y and W-135) conjugate vaccine

INITIATION Prerequisites (tick boxes where appropriate) () Up to three doses and a booster every five years for patients pre- and post splenectomy and for patients with HIV, complement deficiency (acquired or inherited), functional or anatomic asplenia or pre or post solid organ transplant or One dose for close contacts of meningococcal cases of any group or One dose for person who has previously had meningococcal disease of any group or A maximum of two doses for bone marrow transplant patients or A maximum of two doses for person pre and post-immunosuppression* or () Person is aged between 13 and 25 years, inclusive and \bigcirc One dose for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, or prisons or ()One dose for individuals who turn 13 years of age while living in boarding school hostels

Note: children under seven years of age require two doses 8 weeks apart, a booster dose three years after the primary series and then five yearly. *Immunosuppression due to steroid or other immunosuppressive therapy must be for a period of greater than 28 days.

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:

Meningococcal (A, C, Y and W-135) conjugate vaccine

INITIATION – Children under 12 months of age Prerequisites (tick boxes where appropriate)			
_	0	A maximum of three doses (dependant on age at first dose) for patients pre- and post- splenectomy and for patients with functional or	
or		anatomic asplenia, HIV, complement deficiency (acquired or inherited), or pre- or post- solid organ transplant	
o r	Ο	A maximum of three doses (dependant on age at first dose) for close contacts of meningococcal cases of any group	
or	Ο	A maximum of three doses (dependant on age at first dose) for child who has previously had meningococcal disease of any group	
or	0	A maximum of three doses (dependant on age at first dose) for bone marrow transplant patients	
or	0	A maximum of three doses (dependant on age at first dose) for child pre- and post-immunosuppression*	

Note: infants from 6 weeks to less than 6 months of age require a 2+1 schedule, infants from 6 months to less than 12 months of age require a 1+1 schedule. Refer to the Immunisation Handbook for recommended booster schedules with meningococcal ACWY vaccine. *Immunosuppression due to steroid or other immunosuppressive therapy must be for a period of greater than 28 days.

HOSPITAL MEDICINES LIST

April 2025	RESTRICTION	IS 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		PATIENT:	
Name:		Name:	
Ward:		NHI:	
Pneumococcal (PCV13) conjugate vaccine		
Re-assessment requ	ry course for previously unvaccinated children aged ired after 3 doses box where appropriate)	under 5 years	
	course of three doses for previously unvaccinated childre	a up to the age of 50 months inclusive	
	course of three doses for previously unvaccinated children		
INITIATION – High I Re-assessment requ	risk individuals who have received PCV10 uired after 2 doses		
Prerequisites (tick b	pox where appropriate)		
	are funded for high risk individuals (over the age of 12 nurse of PCV10	nonths and under 18 years) who have previously received two doses of the	
Re-assessment requ	r isk children aged under 5 years lired after 4 doses boxes where appropriate)		
and Up to	o an additional four doses (as appropriate) are funded for	the (re)immunisation of high-risk children aged under 5 years	
	On immunosuppressive therapy or radiation therapy, va	ccinate when there is expected to be a sufficient immune response	
or O	Primary immune deficiencies		
or O	HIV infection		
or O	Renal failure, or nephrotic syndrome		
or O	Are immune-suppressed following organ transplantation	(including haematopoietic stem cell transplant)	
or O	Cochlear implants or intracranial shunts		
or O	Cerebrospinal fluid leaks		
or O	Receiving corticosteroid therapy for more than two weel	ks, and who are on an equivalent daily dosage of prednisone of 2 mg/kg	
or	per day or greater, or children who weigh more than 10		
or _	Chronic pulmonary disease (including asthma treated w	ith high-dose corticosteroid therapy)	
or O	Pre term infants, born before 28 weeks gestation		
or O	Cardiac disease, with cyanosis or failure		
	Diabetes		
or O	Down syndrome		

 $O\;$ Who are pre-or post-splenectomy, or with functional asplenia

I confirm that the above details are correct:

or

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:	
Pneumococcal (PCV13) conjugate vaccine - continued		
INITIATION – High risk individuals 5 years and over Re-assessment required after 4 doses Prerequisites (tick box where appropriate) O Up to an additional four doses (as appropriate) are funded for the (re haematopoietic stem cell transplantation, or chemotherapy; pre- or present the standard sta	e-)immunisation of individuals 5 years and over with HIV, pre or post bost splenectomy; functional asplenia, pre- or post- solid organ transplant, ear implants, intracranial shunts, cerebrospinal fluid leaks or primary	
immunodeficiency		
INITIATION – Testing for primary immunodeficiency diseases Prerequisites (tick box where appropriate)		
O For use in testing for primary immunodeficiency diseases, on the re-	commendation of an internal medicine physician or paediatrician	
Note: Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes		

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:	ame: Name:	
Ward:		NHI:
Pneumococc	al (PPV23) polysaccharide vaccine	
Re-assessment Prerequisites (t O For pa asplen		splant, or chemotherapy; pre- or post-splenectomy; or with functional ent deficiency (acquired or inherited), cochlear implants, or primary
Re-assessment	igh risk children required after 2 doses tick boxes where appropriate)	
and or	 With primary immune deficiencies With HIV infection With renal failure, or nephrotic syndrome Who are immune-suppressed following organ transplanta With cochlear implants or intracranial shunts With cerebrospinal fluid leaks 	s, and who are on an equivalent daily dosage of prednisone of 2 mg/kg g on a total daily dosage of 20 mg or greater d with high-dose corticosteroid therapy)

INITIATION – Testing for primary immunodeficiency diseases Prerequisites (tick box where appropriate)

O For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician

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:
Salmonella typhi vaccine	
INITIATION Prerequisites (tick box where appropriate)	
${ m O}~$ For use during typhoid fever outbreaks	

and

 \bigcirc

or O

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.			

PRESCRIB	ER	PATIENT:
Name:		Name:
Ward:		NHI:
Meningoo	coccal B multicomponent vaccine	
	I – Primary immunisation for children up to 12 months of age	
	nent required after 3 doses tes (tick boxes where appropriate)	
or	D Three doses for children up to 12 months of age (inclusive) fo	r primary immunisation
	D Up to three doses (dependent on age at first dose) for a catch (inclusive) for primary immunisation, from 1 March 2023 to 31	-up programme for children from 13 months to 59 months of age August 2025
	I – Person is one year of age or over tes (tick boxes where appropriate)	
	D Up to two doses and a booster every five years for patients pr asplenia, HIV, complement deficiency (acquired or inherited),	e- and post-splenectomy and for patients with functional or anatomic or pre- or post-solid organ transplant
or (${\sf O}$ Up to two doses for close contacts of meningococcal cases of	any group
or (${\sf O}~$ Up to two doses for person who has previously had meningod	occal disease of any group
or (O Up to two doses for bone marrow transplant patients	
or (O Up to two doses for person pre- and post-immunosuppression	*
	I – Person is aged between 13 and 25 years (inclusive) nent required after 2 doses	
	tes (tick boxes where appropriate)	
	D Person is aged between 13 and 25 years (inclusive)	

Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons

Two doses for individuals who turn 13 years of age while living in boarding school hostels

Note: *Immunosuppression due to corticosteroid or other immunosuppressive therapy must be for a period of greater than 28 days.

I confirm that the above details are correct:

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.

PRES	SCRI	BER		PATIENT:
Name	e:			Name:
Ward:	:			NHI:
Нера	atiti	s A y	vaccine	
INITI Prere			(tick boxes where appropriate)	
		0	Two vaccinations for use in transplant patients	
	or	Ο	Two vaccinations for use in children with chronic liver disease	
	or	0	One dose of vaccine for close contacts of known hepatitis A ca	ases

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:	

Hepatitis B recombinant vaccine

INITIATION Prerequisites (tick boxes where appropriate) () For household or sexual contacts of known acute hepatitis B patients or hepatitis B carriers or For children born to mothers who are hepatitis B surface antigen (HBsAg) positive or For children up to and under the age of 18 years inclusive who are considered not to have achieved a positive serology and require additional vaccination or require a primary course of vaccination or ()For HIV positive patients or For hepatitis C positive patients or For patients following non-consensual sexual intercourse or For patients prior to planned immunosuppression for greater than 28 days or () For patients following immunosuppression or For solid organ transplant patients or For post-haematopoietic stem cell transplant (HSCT) patients or Following needle stick injury or For dialysis patients or For liver or kidney transplant patients

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:	

Hepatitis B recombinant vaccine

INITIATION Prerequisites (tick boxes where appropriate) () For household or sexual contacts of known acute hepatitis B patients or hepatitis B carriers or For children born to mothers who are hepatitis B surface antigen (HBsAg) positive or For children up to and under the age of 18 years inclusive who are considered not to have achieved a positive serology and require additional vaccination or require a primary course of vaccination or ()For HIV positive patients or For hepatitis C positive patients or For patients following non-consensual sexual intercourse or For patients prior to planned immunosuppression for greater than 28 days or () For patients following immunosuppression or For solid organ transplant patients or For post-haematopoietic stem cell transplant (HSCT) patients or Following needle stick injury

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:
Influenza vaccine Inj 60 mcg in 0.5 ml syringe (quadrivalen	t vaccine)
INITIATION – People over 65 Prerequisites (tick box where appropriate)	
O The patient is 65 years of age or over	
INITIATION – cardiovascular disease Prerequisites (tick boxes where appropriate)	
O Ischaemic heart disease	
O Congestive heart failure	
C Rheumatic heart disease	

or Congenital heart disease

Note: hypertension and/or dyslipidaemia without evidence of end-organ disease is excluded from funding.

INITIATION – chronic respiratory disease

or

Prerequisites (tick boxes where appropriate)

O Asthma, if on a regular preventative therapy

O Other chronic respiratory disease with impaired lung function

Note: asthma not requiring regular preventative therapy is excluded from funding.

I confirm that the above details are correct:

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:		

Influenza vaccine Inj 60 mcg in 0.5 ml syringe (quadrivalent vaccine) - continued

	Ο	Diabetes
	or ()	Chronic renal disease
	or ()	Any cancer, excluding basal and squamous skin cancers if not invasive
	or ()	Autoimmune disease
	or ()	Immune suppression or immune deficiency
	or ()	HIV
	or ()	Transplant recipient
	or ()	Neuromuscular and CNS diseases/ disorders
	or ()	Haemoglobinopathies
	or ()	Is a child on long term aspirin
	or ()	Has a cochlear implant
	or ()	Errors of metabolism at risk of major metabolic decompensation
	or ()	Pre and post splenectomy
		Down syndrome
	or ()	Is pregnant
•	or ()	Is a child 4 years of age or under (inclusive) who has been hospitalised for respiratory illness or has a history of significant respiratory illness
r C) Patie Hos	ents in a long-stay inpatient mental health care unit or who are compulsorily detained long-term in a forensic unit within a Publi oital
	– Serio	us mental health conditions or addiction

~ "	\bigcirc	Schizophrenia
or	Ο	Major depressive disorder
or	Ο	Bipolar disorder
or	Ο	Schizoaffective disorder
or	0	Person is currently accessing secondary or tertiary mental health and addiction services

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:
Measles, mumps and rubella vaccine	
INITIATION – first dose prior to 12 months Re-assessment required after 3 doses Prerequisites (tick boxes where appropriate) O For primary vaccination in children or O or For revaccination following immunosuppression or O For any individual susceptible to measles, mumps or rubella	
INITIATION - first dose after 12 months Re-assessment required after 2 doses Prerequisites (tick boxes where appropriate) O For primary vaccination in children or O or For revaccination following immunosuppression or O or For any individual susceptible to measles, mumps or rubella	

Note: Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes.

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.

PRES	SCR	IBER	PATIENT:
Name	e:		Name:
Ward:	:		NHI:
Polic	om	yelitis vaccine	
	sse	sssment required after 3 doses isites (tick boxes where appropriate) O For partially vaccinated or previously unvaccinated individuals	

Note: Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes.

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.

Name:		PATIENT:
		Name:
Ward:		NHI:
Varicella vao	ccine [Chickenpox vaccine]	
	primary vaccinations t required after 1 dose	
	(tick boxes where appropriate)	
or O	Any infant born on or after 1 April 2016	er efter 1. July 2017, who have not any involve had a write lie infection
	(chickenpox)	or after 1 July 2017, who have not previously had a varicella infection
Re-assessmen	other conditions t required after 2 doses (tick boxes where appropriate)	
or or or	for non-immune patients: O With chronic liver disease who may in future be candid O With deteriorating renal function before transplantation O Prior to solid organ transplant O Prior to any elective immunosuppression*	ates for transplantation

greater than 28 days

I confirm that the above details are correct:

and

and

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	PATIENT:
Name:	Name:
Ward:	NHI:

Human papillomavirus (6, 11, 16, 18, 31, 33, 45, 52 and 58) vaccine [HPV]

INITIATION – Children aged 14 years and under Re-assessment required after 2 doses Prerequisites (tick box where appropriate)	
O Children aged 14 years and under	

or	O Up to 3 doses for people aged 15 to 26 years inclusive Image: Constraint of the system o
	ON – Recurrent Respiratory Papillomatosis sites (tick boxes where appropriate) O Maximum of two doses for children aged 14 years and under

or		
\cap		
	Maximum of three doses for people aged 15 years and over	

 $m O\,$ The person has recurrent respiratory papillomatosis

m O The person has not previously had an HPV vaccine

I confirm that the above details are correct:

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:		
Rotavirus oral vaccine			
INITIATION Re-assessment required after 2 doses			
Prerequisites (tick boxes where appropriate)			
O First dose to be administered in infants aged under 14 weeks of age			
No vaccination being administered to children aged 24 weeks	or over		

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.

PRES	CRII	BER		PATIENT:		
Name				Name:		
Ward:				NHI:		
Varic	ella	a zos	ster vaccine [shingles vaccine]			
	INITIATION – people aged 18 years and over (Shingrix) Re-assessment required after 2 doses					
Prere	qui	sites	(tick boxes where appropriate)			
		0	Pre- and post-haematopoietic stem cell transplant or cellular th	lerapy		
	or	Ο	Pre- or post-solid organ transplant			
	or	Ο	Haematological malignancies			
	or	Ο	People living with poorly controlled HIV infection			
	or	Ο		DMARDs – targeted synthetic, biologic, or conventional synthetic) for		
	or		polymyalgia rheumatica, systemic lupus erythematosus or rheu	umatoid arthritis		
	or	\bigcirc	End stage kidney disease (CKD 4 or 5);			
		Ο	Primary immunodeficiency			

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:
COVID-19 vaccine	
INITIATION – initial dose	

Prerequisites (tick box where appropriate)

m O Up to three doses for previously unvaccinated children aged 6 months – 4 years at high risk of severe illness

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.

PRES	SCR	IBER		PATIENT:
Name	e:			Name:
Ward:	:			NHI:
cov	ID-	19 va	accine	
INITIATION – initial dose Prerequisites (tick boxes where appropriate)				
		0	One dose for previously unvaccinated children aged 5-11 year	s old
	or	0	Up to three doses for immunocompromised children aged 5-11	years old

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:		

COVID-19 vaccine

INITIATION – initial dose Prerequisites (tick boxes where appropriate)					
_					

INITIATION – additional dose

Prerequisites (tick box where appropriate)

O One additional dose every 6 months for people aged 30 years and over, additional dose is given at least 6 months after last dose

CONTINUATION – additional dose

Prerequisites (tick box where appropriate)

O One additional dose every 6 months for people aged 30 years and over, additional dose is given at least 6 months after last dose

I confirm that the above details are correct:

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Nilotinib (RS2010)	281
Nintedanib (RS1813)	
Niraparib (RS2027)	100
Nitazoxanide (RS1095)	202
Nivolumab (RS2113)	425
Non-Nucleoside Reverse Transcriptase Inhibitors (RS1898)	203
Nonacog gamma (RS1679)	58
Nucleoside Reverse Transcriptase Inhibitors (RS1899)	204
Nusinersen (RS1938)	054
Obieutururuk (DO1010)	204
Obinutuzumab (RS1919)	343
Octocog alfa [Recombinant factor VIII] (Advate) (RS1707)	56
Octocog alfa [Recombinant factor VIII] (Kogenate FS) (RS1708)	57
Olanzapine (RS2018)	245
Olaparib (RS1925)	271
Omalizumab (RS1652)	240
Omeprazole - Tab dispersible 20 mg (RS1027)	8
Oseltamivir (RS1307)	213
Osimertinib (RS2080) Oxandrolone - Tab 2.5 mg (RS1302)	289
Oxandrolone - Tab 2.5 mg (RS1302)	118
Paediatric Products (RS1473)	180
Paediatric oral/enteral feed 1 kcal/ml (RS1614)	405
	485
Palbociclib (Ibrance) (RS2034)	284
Paliperidone (RS2059)	243
Paliperidone palmitate (RS1932)	244
Palivizumab (RS2081)	390
	450
Paper wasp venom (RS1118)	403
Para-aminosalicylic Acid (RS1083)	
Paracetamol (RS1146)	236
Paromomycin (RS1603)	137
Pazopanib (RS2089)	297
Pegaspargase (RS1788)	280
Pegfilgrastim (RS1743)	200
Pegylated interferon alfa-2a (RS1827)	
Pembrolizumab (RS2056)	430
Pentamidine isethionate (RS1096)	196
Pertuzumab (RS1995)	344
Pimecrolimus (RS1781) Piperacillin with tazobactam (RS1053)	109
Piperacillin with tazobactam (RS1053)	150
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Pirfenidone (RS1814)	458
Pirfenidone (RS1814) Pivmecillinam (RS1322)	160
Pirfenidone (RS1814) Pivmecillinam (RS1322)	160
Pirfenidone (RS1814) Pivmecillinam (RS1322) Plerixafor (RS1536)	160 71
Pirfenidone (RS1814) Pivmecillinam (RS1322) Plerixafor (RS1536) Pneumococcal (PCV13) conjugate vaccine (RS1936)	160 71 503
Pirfenidone (RS1814) Pivmecillinam (RS1322) Plerixafor (RS1536) Pneumococcal (PCV13) conjugate vaccine (RS1936) Pneumococcal (PPV23) polysaccharide vaccine (RS1587)	160 71 503 505
Pirfenidone (RS1814) Pivmecillinam (RS1322) Plerixafor (RS1536) Pneumococcal (PCV13) conjugate vaccine (RS1936) Pneumococcal (PPV23) polysaccharide vaccine (RS1587) Poliomyelitis vaccine (RS1398)	160 71 503 505 514
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Pirfenidone (RS1814) Pivmecillinam (RS1322) Plerixafor (RS1536) Pneumococcal (PCV13) conjugate vaccine (RS1936) Pneumococcal (PPV23) polysaccharide vaccine (RS1587) Poliomyelitis vaccine (RS1398) Pomalidomide (RS2045)	160 71 503 505 514 276
Pirfenidone (RS1814) Pivmecillinam (RS1322) Plerixafor (RS1536) Pneumococcal (PCV13) conjugate vaccine (RS1936) Pneumococcal (PPV23) polysaccharide vaccine (RS1587) Poliomyelitis vaccine (RS1398) Pomalidomide (RS2045) Posaconazole (RS2052)	160 71 503 505 514 276 173
Pirfenidone (RS1814) Pivmecillinam (RS1322) Plerixafor (RS1536) Pneumococcal (PCV13) conjugate vaccine (RS1936) Pneumococcal (PPV23) polysaccharide vaccine (RS1587) Poliomyelitis vaccine (RS1398) Pomalidomide (RS2045) Posaconazole (RS2052) Potassium citrate (RS1133)	160 71 503 505 514 276 173 116
Pirfenidone (RS1814) Pivmecillinam (RS1322) Plerixafor (RS1536) Pneumococcal (PCV13) conjugate vaccine (RS1936) Pneumococcal (PPV23) polysaccharide vaccine (RS1587) Poliomyelitis vaccine (RS1398) Pomalidomide (RS2045) Posaconazole (RS2052) Potassium citrate (RS1133) Povidone-iodine - Vaginal tab 200 mg (RS1354)	160 71 503 505 514 276 173 116 469
Pirfenidone (RS1814) Pivmecillinam (RS1322) Plerixafor (RS1536) Pneumococcal (PCV13) conjugate vaccine (RS1936) Pneumococcal (PPV23) polysaccharide vaccine (RS1587) Poliomyelitis vaccine (RS1398) Pomalidomide (RS2045) Posaconazole (RS2052) Potassium citrate (RS1133) Povidone-iodine - Vaginal tab 200 mg (RS1354) Preoperative carbohydrate feed 0.5 kcal/ml (RS1415)	160 71 503 505 514 276 173 116 469 492
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