HOSPITAL MEDICINES LIST
RESTRICTIONS CHECKLIST

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

PRESCRIBER

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Epoetin beta

INITIATION – chronic renal failure

Prerequisites (tick boxes where appropriate)

- ○ Patient in chronic renal failure

and

- ○ Haemoglobin is less than or equal to 100g/L

and

- ○ Patient does not have diabetes mellitus

  and

  ○ Glomerular filtration rate is less than or equal to 30ml/min

  or

- ○ Patient has diabetes mellitus

  and

  ○ Glomerular filtration rate is less than or equal to 45ml/min

  or

- ○ Patient is on haemodialysis or peritoneal dialysis

INITIATION – myelodysplasia*

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

- ○ Patient has a confirmed diagnosis of myelodysplasia (MDS)

and

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

and

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

and

- ○ Other causes of anaemia such as B12 and folate deficiency have been excluded

and

- ○ Patient has a serum epoetin level of < 500 IU/L

and

- ○ 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)

- ○ The patient's transfusion requirement continues to be reduced with epoetin treatment

and

- ○ Transformation to acute myeloid leukaemia has not occurred

and

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

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

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Epoetin beta *- continued*

INITIATION – all other indications

Prerequisites (tick boxes where appropriate)

- ❍ Haematologist

and

- ❍ For use in patients where blood transfusion is not a viable treatment alternative

and

- ❍ *Note: Indications marked with * are unapproved indications

I confirm that the above details are correct:

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