Use this checklist to determine if a patient meets the restrictions for 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:	
Bevacizumab			
Re-a	NITIATION – Recurrent Respiratory Papillomatosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by an otolaryngologist, or in accordance with a protocol or guideline that has been endorsed by 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)  Orescribed by, or recommended by an otolaryngologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
und	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  Exudative ocular angiopathy		

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