

Use this checklist to determine if a patient meets the restrictions for funding 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: .....

**Dornase alfa**

**INITIATION – cystic fibrosis**

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

- ☐ 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

- ☐ Patient has a confirmed diagnosis of cystic fibrosis

and

- ☐ Patient has previously undergone a trial with, or is currently being treated with, hypertonic saline

and

- ☐ Patient has required one or more hospital inpatient respiratory admissions in the previous 12 month period
- or
- ☐ Patient has had 3 exacerbations due to CF, requiring oral or intravenous (IV) antibiotics in the previous 12 month period
- or
- ☐ 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
- or
- ☐ Patient has a diagnosis of allergic bronchopulmonary aspergillosis (ABPA)

**CONTINUATION – cystic fibrosis**

**Prerequisites** (tick box where appropriate)

- ☐ 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

- ☐ 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)

- ☐ 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)

- ☐ Patient is an in-patient
- and
- ☐ Patient diagnoses with pleural emphyema

I confirm that the above details are correct:

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