Use this checklist to determine if a patient meets the restrictions for funding in the **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:	
Ranibizumab		
INITIATION – Wet Age Rel Re-assessment required aff Prerequisites (tick boxes w Prescribed by, or endorsed by the F and or or and There and Patier Or Patient has CONTINUATION – Wet Ag Re-assessment required aff Prerequisites (tick boxes w Prescribed by, or	where appropriate) recommended by an ophthalmologist or nurse practitioner, or in accordance with a protocol or guideline that has been dealth NZ Hospital. Wet age-related macular degeneration (wet AMD) Polypoidal choroidal vasculopathy Choroidal neovascular membrane from causes other than wet AMD The patient has developed severe endophthalmitis or severe posterior uveitis following treatment with bevacizumab There is worsening of vision or failure of retina to dry despite three intraocular injections of bevacizumab four weeks apart is no structural damage to the central fovea of the treated eye in thas not previously been treated with aflibercept for longer than 3 months current approval to use aflibercept for treatment of wAMD and was found to be intolerant to aflibercept within 3 months e Related Macular Degeneration ter 12 months	
and O Documenter	d benefit must be demonstrated to continue sion 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:	
Signed:	Date: