

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

Aflibercept

INITIATION – Wet Age Related Macular Degeneration

Re-assessment required after 3 months

Prerequisites (tick boxes where appropriate)

- ☐ 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

- ☐ Wet age-related macular degeneration (wet AMD)
or
☐ Polypoidal choroidal vasculopathy
or
☐ Choroidal neovascular membrane from causes other than wet AMD

and

- ☐ The patient has developed severe endophthalmitis or severe posterior uveitis following treatment with bevacizumab
or
☐ There is worsening of vision or failure of retina to dry despite three intraocular injections of bevacizumab four weeks apart

and

- ☐ There is no structural damage to the central fovea of the treated eye
and
☐ Patient has not previously been treated with ranibizumab for longer than 3 months

or

- ☐ Patient has current approval to use ranibizumab for treatment of wAMD and was found to be intolerant to ranibizumab within 3 months
or
☐ Patient has previously* (*before June 2018) received treatment with ranibizumab for wAMD and disease was stable while on treatment

CONTINUATION – Wet Age Related Macular Degeneration

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

- ☐ 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

- ☐ Documented benefit must be demonstrated to continue
and
☐ Patient's vision is 6/36 or better on the Snellen visual acuity score
and
☐ There is no structural damage to the central fovea of the treated eye

I confirm that the above details are correct:

Signed: Date:

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PRESCRIBER

Name:

Ward:

PATIENT:

Name:

NHI:

Aflibercept - continued

INITIATION – Diabetic Macular Oedema

Re-assessment required after 4 months

Prerequisites (tick boxes where appropriate)

- ☐ 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

- ☐ Patient has centre involving diabetic macular oedema (DMO)
- and ☐ Patient's disease is non responsive to 4 doses of intravitreal bevacizumab when administered 4-6 weekly
- and ☐ Patient has reduced visual acuity between 6/9 – 6/36 with functional awareness of reduction in vision
- and ☐ Patient has DMO within central OCT (ocular coherence tomography) subfield > 350 micrometers
- and ☐ There is no centre-involving sub-retinal fibrosis or foveal atrophy

CONTINUATION – Diabetic Macular Oedema

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

- ☐ 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

- ☐ There is stability or two lines of Snellen visual acuity gain
- and ☐ There is structural improvement on OCT scan (with reduction in intra-retinal cysts, central retinal thickness, and sub-retinal fluid)
- and ☐ Patient's vision is 6/36 or better on the Snellen visual acuity score
- and ☐ There is no centre-involving sub-retinal fibrosis or foveal atrophy
- and ☐ After each consecutive 12 months treatment with aflibercept, patient has retrialled with at least one injection of bevacizumab and had no response

I confirm that the above details are correct:

Signed: Date: