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: .....

Long-acting Somatostatin Analogues

INITIATION – Malignant bowel obstruction

Prerequisites (tick boxes where appropriate)

- ○ The patient has nausea* and vomiting* due to malignant bowel obstruction*

and

- ○ Treatment with antiemetics, rehydration, antimuscarinic agents, corticosteroids and analgesics for at least 48 hours has not been successful

and

- ○ Treatment to be given for up to 4 weeks

Note: Indications marked with * are unapproved indications

INITIATION – acromegaly

Re-assessment required after 3 months

Prerequisites (tick boxes where appropriate)

- ○ The patient has acromegaly

and

- ○ Treatment with surgery and radiotherapy is not suitable or was unsuccessful

or

- ○ Treatment is for an interim period while awaiting the beneficial effects of radiotherapy

and

- ○ Treatment with a dopamine agonist has been unsuccessful

CONTINUATION – acromegaly

Prerequisites (tick box where appropriate)

- ○ Without reassessment for applications where IGF1 levels have decreased since starting treatment

Note: In patients with acromegaly, treatment should be discontinued if IGF1 levels have no decreased 3 months after treatment. In patients treated with radiotherapy treatment should be withdrawn every 2 years, for 1 month, for assessment of remission. Treatment should be stopped where there is biochemical evidence of remission (normal IGF1 levels) following treatment withdrawal for at least 4 weeks.

I confirm that the above details are correct:

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

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PRESCRIBER

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Long-acting Somatostatin Analogues *- continued*

INITIATION – Other indications

Prerequisites (tick boxes where appropriate)

- ○ VIPomas and glucagonomas - for patients who are seriously ill in order to improve their clinical state prior to definitive surgery

or

- ○ Gastrinoma

and

- ○ Surgery has been unsuccessful

or

- ○ Patient has metastatic disease after treatment with H2 antagonist or proton pump inhibitors has been unsuccessful

or

- ○ Insulinomas

and

- ○ Surgery is contraindicated or has not been successful

or

- ○ For pre-operative control of hypoglycaemia and for maintenance therapy

or

- ○ Carcinoid syndrome (diagnosed by tissue pathology and/or urinary 5HIAA analysis)

and

- ○ Disabling symptoms not controlled by maximal medical therapy

INITIATION – pre-operative acromegaly

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

- ○ Patient has acromegaly

and

- ○ Patient has a large pituitary tumour, greater than 10 mm at its widest

and

- ○ Patient is scheduled to undergo pituitary surgery in the next six months

Note: Indications marked with * are unapproved indications

Note: The use of a long-acting somatostatin analogue in patients with fistulae, oesophageal varices, miscellaneous diarrhoea and hypotension will not be funded under Special Authority

I confirm that the above details are correct:

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