

Therapeutic Groups

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ndex of titles	

Alimentary Tract and Metabolism



PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Calcium carbonate			
INITIATION Prerequisites (tick box where appropriate)			
Only when prescribed for patients unable to swallow calcium carbonate tablets or where calcium carbonate tablets are inappropriate.			

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Signeg	 Date	

May 2025

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

CRIBER		PATIENT:	
:		Name:	
		NHI:	
sonide			
	Crohn's disease (tick boxes where appropriate)		
O and	Mild to moderate ileal, ileocaecal or proximal Crohn's dise	ase	
	O Diabetes		
or	O Cushingoid habitus		
or	O Osteoporosis where there is significant risk of fractu	re	
or	O Severe acne following treatment with conventional c	orticosteroid therapy	
or History of severe psychiatric problems associated with corticosteroid treatment			
or		ctive disorder) where the risk of conventional corticosteroid treatment	
or	Relapse during pregnancy (where conventional corti	icosteroids are considered to be contraindicated)	
ATION C	Collagenous and lymphocytic colitis (microscopic colit	io)	
	(tick box where appropriate)	15)	
) Patier	nt has a diagnosis of microscopic colitis (collagenous or lyn	nphocytic colitis) by colonoscopy with biopsies	
	Gut Graft versus Host disease (tick box where appropriate)		
	O Patient has gut Graft versus Host disease following allogenic bone marrow transplantation		

I confirm that the above details are correct: Signed: Date:

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIB	ER			PATIENT:
Name:				Name:
Ward:				NHI:
Budesoni	ide	- cor	ntinued	
Re-assessr	nent	requ	irrhotic autoimmune hepatitis ired after 6 months poxes where appropriate)	
	C	Patie	nt has autoimmune hepatitis*	
and (C	Patie	ent does not have cirrhosis	
		O	Diabetes	
	or or	0	Cushingoid habitus	
	Osteoporosis where there is significant risk of fracture or O Severe acne following treatment with conventional corticosteroid therapy			
				costeroid therapy
	or	0	History of severe psychiatric problems associated with o	corticosteroid treatment
	or	0	History of major mental illness (such as bipolar affective causing relapse is considered to be high	disorder) where the risk of conventional corticosteroid treatment
		0	Relapse during pregnancy (where conventional corticos	teroids are considered to be contraindicated)
	or	0	Adolescents with poor linear growth (where conventional	Il corticosteroid use may limit further growth)
Note: Indications marked with * are unapproved indications.				
Re-assessr Prerequisi	neni tes (requ (tick b	non-cirrhotic autoimmune hepatitis ired after 6 months oox where appropriate) remains appropriate and the patient is benefitting from the	e treatment

Form RS1703 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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	SCR	RIBER		PATIENT:
Name	э: .			Name:
Ward	:			NHI:
Rani	itid	ine		
INITI Prer			(tick boxes where appropriate)	
		0	For continuation use	
	or	O	Routine prevention of allergic reactions.	

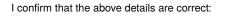
I confirm that the above details are correct:

Signed: Date:

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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:	Name:
Ward:	NHI:
Omeprazole - Tab dispersible 20 mg	
INITIATION Prerequisites (tick box where appropriate)	
Only for use in tube-fed patients	



Signed: Date:

Form RS1261 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:	Name:		
Ward:	NHI:		
L-ornithine L-aspartate			
INITIATION			
Prerequisites (tick box where appropriate)			
O For patients with chronic hepatic encephalopathy who have not responded to treatment with, or are intolerant to lactulose, or where lactulose is contraindicated			

Form RS1416 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Rifaximin				
INITIATION Prerequisites (tick box where appropriate)				
O For patients with hepatic encephalopathy despite an adequate trial of maximum tolerated doses of lactulose				

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Signed.	Date:	
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Form RS1028 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:	Name:
Ward:	NHI:
Diazoxide	
INITIATION Prerequisites (tick box where appropriate)	
O For patients with confirmed hypoglycaemia caused by hyperinsulinis	sm

I confirm that the above details are correct:

Signed: Date:

Form RS2102 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 12

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:	Name:
Ward:	NHI:
Dulaglutide	
INITIATION Prerequisites (tick box where appropriate)	
O For continuation only	

I confirm that the above details are correct:

Signed: Date:

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.

PRI	SCRIB	ER		PATIENT:	
Nar	ne:			Name:	
Wa	d:			NHI:	
Lira	aglutio	de			
	TIATIO		ick b	es where appropriate)	
	or	О ғ	or c	inuation use	
		and	or or or	arient has type 2 diabetes arget HbA1c (of 53 mmol/mol or less) has not been achieved despite the regular use of all of the following funded blood accose lowering agents for a period of least 6 months, where clinically appropriate: empagliflozin, metformin, and vildagliptin Patient is Māori or any Pacific ethnicity* Patient has pre-existing cardiovascular disease or risk equivalent (see note a)* Patient has an absolute 5-year cardiovascular disease risk of 15% or greater according to a validated cardiovascular risk assessment calculator* Patient has a high lifetime cardiovascular risk due to being diagnosed with type 2 diabetes during childhood or as a young adult* Patient has diabetic kidney disease (see note b)*	
No	te: * Cr	iteria i	nten	d to describe patients at high risk of cardiovascular or renal complications of diabetes.	
a)	a) Pre-existing cardiovascular disease or risk equivalent defined as: prior cardiovascular disease event (i.e. angina, myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, transient ischaemic attack, ischaemic stroke, peripheral vascular disease), congestive heart failure or familial hypercholesterolaemia.				
b)	b) Diabetic kidney disease defined as: persistent albuminuria (albumin:creatinine ratio greater than or equal to 3 mg/mmol, in at least two out of three samples over a 3-6 month period) and/or eGFR less than 60 mL/min/1.73m2 in the presence of diabetes, without alternative cause identified.				
c)) Funded GLP-1a treatment is not to be given in combination with (empagliflozin / empagliflozin with metformin hydrochloride) unless receiving (empagliflozin or empagliflozin in combination with metformin hydrochloride) for the treatment of heart failure.				

I confirm that the above details are correct:

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Signed.	Date:	
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I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Empagliflozin; Empagliflozin with metformin hydrochlori	de		
INITIATION – heart failure reduced ejection fraction Prerequisites (tick boxes where appropriate)			
and O Patient is receiving concomitant optimal standard funded ch	pinion of the treating practitioner the patient would benefit from treatment		
INITIATION – Type 2 Diabetes Prerequisites (tick boxes where appropriate) For continuation use			
or Patient has previously had an initial approval for a GLP-1 ag or Patient has type 2 diabetes and	gonist		
or risk assessment calculator* Patient has a high lifetime cardiovascular risk di young adult* Patient has diabetic kidney disease (see note b	disease risk of 15% or greater according to a validated cardiovascular ue to being diagnosed with type 2 diabetes during childhood or as a		
Note: * Criteria intended to describe patients at high risk of cardiovascular describes patients at high risk of cardiovascular describes patients.	or renal complications of diabetes.		
coronary intervention, coronary artery bypass grafting, transient ischaer failure or familial hypercholesterolaemia. b) Diabetic kidney disease defined as: persistent albuminuria (albumin:cre samples over a 3-6 month period) and/or eGFR less than 60 mL/min/1.	atment is not to be given in combination with a funded GLP-1 unless receiving		

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

May 2025

PRESCRIBER PATIENT:			
Name: Name:			
Ward: NHI:			
Ursodeoxycholic acid			
INITIATION – Alagille syndrome or progressive familial intrahepatic cholestasis Prerequisites (tick boxes where appropriate)			
O Patient has been diagnosed with Alagille syndrome O Patient has progressive familial intrahepatic cholestasis			
INITIATION – Chronic severe drug induced cholestatic liver injury Prerequisites (tick boxes where appropriate)			
Patient has chronic severe drug induced cholestatic liver injury and Cholestatic liver injury not due to Total Parenteral Nutrition (TPN) use in adults			
and Treatment with ursodeoxycholic acid may prevent hospital admission or reduce duration of stay			
INITIATION – Primary biliary cholangitis Prerequisites (tick boxes where appropriate)			
Primary biliary cholangitis confirmed by antimitochondrial antibody titre (AMA) > 1:80, and raised cholestatic liver enzymes with or without raised serum IgM or, if AMA is negative by liver biopsy and Patient not requiring a liver transplant (bilirubin > 100 umol/l; decompensated cirrhosis			
INITIATION – Pregnancy Prerequisites (tick box where appropriate) O Patient diagnosed with cholestasis of pregnancy			
INITIATION – Haematological transplant Prerequisites (tick boxes where appropriate)			
Patient at risk of veno-occlusive disease or has hepatic impairment and is undergoing conditioning treatment prior to allogenic stem cell or bone marrow transplantation and Treatment for up to 13 weeks			
INITIATION – Total parenteral nutrition induced cholestasis Prerequisites (tick boxes where appropriate)			
Paediatric patient has developed abnormal liver function as indicated on testing which is likely to be induced by TPN and Liver function has not improved with modifying the TPN composition			
INITIATION – prevention of sinusoidal obstruction syndrome Prerequisites (tick box where appropriate) The individual has leukaemia/lymphoma and requires prophylaxis for medications/therapies with a high risk of sinusoidal obstruction syndrome			

PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Methylnaltrexone bromide				
INITIATION – Opioid induced constipation Prerequisites (tick boxes where appropriate)				
The patient is receiving palliative care				
Oral and rectal treatments for opioid induced constipation are ineffective Oral and rectal treatments for opioid induced constipation are unable to be tolerated				
INITIATION – Opioid induced constipation outside of palliative care Re-assessment required after 14 days Prerequisites (tick boxes where appropriate)				
Individual has opioid induced constipation and Oral and rectal treatments for opioid induced constination, inc	luding bowel-cleansing preparations, are ineffective or inappropriate			
and Mechanical bowel obstruction has been excluded	nading bower decarding preparations, are menective or mappropriate			

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PRES	CRIBER		PATIENT:		
Name:			Name:		
Ward:			NHI:		
sodi	um pico	osulfate			
INITIATION Prerequisites (tick boxes where appropriate)					
	and	The patient is a child with problematic constipation despite an where practicable	adequate trial of other oral pharmacotherapies including macrogol		
	O	The patient would otherwise require a high-volume bowel clea	nsing preparation		

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Betaine				
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)				
Prescribed by, or recommended by a metabolic physician, or in acc NZ Hospital.	ordance with a protocol or guideline that has been endorsed by the Health			
The patient has a confirmed diagnosis of homocystinuria and				
O A cystathionine beta-synthase (CBS) deficiency				
O A 5,10-methylene-tetrahydrofolate reductase (MTHFR)	deficiency			
O A disorder of intracellular cobalamin metabolism				
An appropriate homocysteine level has not been achieved de	spite a sufficient trial of appropriate vitamin supplementation			
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate)				
O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
The treatment remains appropriate and the patient is benefiting from	n treatment			

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Signed.	Date:	
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Form RS1035 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Levocarnitine				
INITIATION				
Prerequisites (tick box where appropriate)				
O Prescribed by, or recommended by a neurologist, metabolic physician or metabolic disorders dietitian, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				

PRESCR	IBER	PATIENT:			
Name:		Name:			
Ward:		NHI:			
Sodium	phenylbutyrate				
Re-asses	INITIATION Re-assessment required after 12 months Prerequisites (tick box where appropriate) Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. For the chronic management of a urea cycle disorder involving a deficiency of carbamylphosphate synthetase, ornithine transcarbamylase or argininosuccinate synthetase				
	ssment required after 12 months isites (tick box where appropriate)	ordance with a protocol or guideline that has been endorsed by the Health			
O	The treatment remains appropriate and the patient is benefiting from treatment				

I confirm that the above details are correct:		
Signed.	Date:	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Biotin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a metabolic physician or metabolic been endorsed by the Health NZ Hospital.	lic disorders dietitian, or in accordance with a protocol or guideline that has

Page 22

PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Pyridoxal-5-phosphate				
INITIATION				
Prerequisites (tick box where appropriate)				
O Prescribed by, or recommended by a neurologist, metabolic physician or metabolic disorders dietitian, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				

PRES	CRIBER		PATIENT:
Name	e:		Name:
Ward	:		NHI:
Gals	ulfase		
Re-a		t required after 12 months (tick boxes where appropriate)	
and) Preso	,	rdance with a protocol or guideline that has been endorsed by the Health
unu	O and	The patient has been diagnosed with mucopolysaccharidosis	VI .
	or	enzyme activity assay in leukocytes or skin fibroblasts	tosamine-4-sulfatase (arylsulfatase B) deficiency confirmed by either has a sibling who is known to have mucopolysaccharidosis VI
Re-a	equisites Preso	It required after 12 months (tick boxes where appropriate) cribed by, or recommended by a metabolic physician, or in acco	rdance with a protocol or guideline that has been endorsed by the Health
and	and O	Ospital. The treatment remains appropriate for the patient and the patient has not had severe infusion-related adverse reactions adjustment of infusion rates	ent is benefiting from treatment which were not preventable by appropriate pre-medication and/or
	and	Patient has not developed another life threatening or severe di Enzyme Replacement Therapy (ERT) Patient has not developed another medical condition that migh	sease where the long term prognosis is unlikely to be influenced by t reasonably be expected to compromise a response to ERT

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May 2025

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	CRIB	BER	PATIENT:		
Name	:		Name:	Name:	
Ward:			NHI:		
Alglu	icos	ida	se Alfa		
	ssess equisi	men ites Preso	nt required after 12 months (tick boxes where appropriate) cribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endospital.	dorsed by the Health	
	(and	0	The patient is aged up to 24 months at the time of initial application and has been diagnosed with infantile Pompe of	disease	
		or or	 Documented deficiency of acid alpha-glucosidase, and urinary tetrasaccharide testing indicating a diagnostic glucose tetrasaccharides Documented deficiency of acid alpha-glucosidase, and documented molecular genetic testing indicating a dismutation in the acid alpha-glucosidase gene (GAA gene) 	elevation of sease-causing	
and Pat rea			Patient has not required long-term invasive ventilation for respiratory failure prior to starting enzyme replacement the Patient does not have another life-threatening or severe disease where the prognosis is unlikely to be influenced by reasonably expected to compromise a response to ERT Alglucosidase alfa to be administered at doses no greater than 20 mg/kg every 2 weeks		
	ssess e quis i	men ites Preso	nt required after 12 months (tick boxes where appropriate) cribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been enclospital.	dorsed by the Health	
and	and (and (and (and (and (and (and (and (The treatment remains appropriate for the patient and the patient is benefiting from treatment Alglucosidase alfa to be administered at doses no greater than 20 mg/kg every 2 weeks Patient has not had severe infusion-related adverse reactions which were not preventable by appropriate pre-medic adjustment of infusion rates Patient has not developed another life threatening or severe disease where the long term prognosis is unlikely to be Patient has not developed another medical condition that might reasonably be expected to compromise a response There is no evidence of life threatening progression of respiratory disease as evidenced by the needed for > 14 da ventilation There is no evidence of new or progressive cardiomyopathy	e influenced by ERT	

I confirm that the above details are correct:

Signed: Date:

PRES	CRIB	ER	PA	ATIENT:
Name	:			ame:
Ward:			NI	4I:
ldurs	ulfa	se		
Re-a	e quisi P	men tes resc	nt required after 24 weeks (tick boxes where appropriate) cribed by, or recommended by a metabolic physician, or in accorda	nce with a protocol or guideline that has been endorsed by the Health
The patient has been diagnosed with Hunter Syndrome (mucopolysacchardosis II)		ysacchardosis II)		
		or	cultured skin fibroblasts	ase deficiency in white blood cells by either enzyme assay in sulfatase gene
	and (<u>С</u>	Patient is going to proceed with a haematopoietic stem cell transp would be bridging treatment to transplant	plant (HSCT) within the next 3 months and treatment with idursulfase
and Patient has not required long-term invasive ventilation for respiratory failure prior to startir and		Patient has not required long-term invasive ventilation for respirate	ory failure prior to starting Enzyme Replacement Therapy (ERT)	
	(C	Idursulfase to be administered for a total of 24 weeks (equivalent 0.5 mg/kg every week	to 12 weeks pre- and 12 weeks post-HSCT) at doses no greater than

I confirm that the above details are correct:	
Signed:	Date:

PRES	CRIB	ER		PATIENT:
Name	:			Name:
Ward:				NHI:
Laro	nida	se		
	ssess equis	men ites Presc	nt required after 24 weeks (tick boxes where appropriate) cribed by, or recommended by a metabolic physician, or in actions and the second sec	cordance with a protocol or guideline that has been endorsed by the Health
	(and	O	The patient has been diagnosed with Hurler Syndrome (muc	copolysacchardosis I-H)
		or	skin fibroblasts	onidase deficiency in white blood cells by either enzyme assay in cultured na-L-iduronidase gene and patient has a sibling who is known to have
	and (\overline{C}	would be bridging treatment to transplant	ransplant (HSCT) within the next 3 months and treatment with laronidase
and)		spiratory failure prior to starting Enzyme Replacement Therapy (ERT) ralent to 12 weeks pre- and 12 post-HSCT) at doses no greater than

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.

	PATIENT:
ame:	
ard:	NHI:
liglucera	se alfa
	ent required after 12 months s (tick boxes where appropriate)
	scribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health Hospital.
and	The patient has a diagnosis of symptomatic type 1 or type 3* Gaucher disease confirmed by the demonstration of specific deficiency of glucocerebrosidase in leukocytes or cultured skin fibroblasts, and genotypic analysis
and	Patient does not have another life-threatening or severe disease where the prognosis is unlikely to be influenced by enzyme replacement therapy (ERT) or the disease might be reasonably expected to compromise a response to ERT
	O Patient has haematological complications of Gaucher disease
	O Patient has skeletal complications of Gaucher disease
	O Patient has significant liver dysfunction or hepatomegaly attributable to Gaucher disease
	O Patient has reduced vital capacity from clinically significant or progressive pulmonary disease due to Gaucher disease
	O Patient is a child and has experienced growth failure with significant decrease in percentile linear growth over a 6-12 month period
and	Taliglucerase alfa is to be administered at a dose no greater than 30 unit/kg every other week rounded to the nearest whole vial (200 units)
te: Indicat	ion marked with * is an unapproved indication
erequisite O Pre	ent required after 3 years s (tick boxes where appropriate) scribed by, or recommended by a metabolic physician or any relevant practitioner on the recommendation of a metabolic physician, or in ordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	Patient has demonstrated a symptomatic improvement and has maintained improvements in the main symptom or symptoms for which therapy was started
and	Patient has demonstrated a clinically objective improvement or no deterioration in haemoglobin levels, platelet counts and liver and
	spleen size
and	
	spleen size RRadiological (MRI) signs of bone activity performed at two years since initiation of treatment, and five yearly thereafter, demonstrate

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PRES	CRIB	ER	PATIENT:		
Name: Name:					
Ward	Vard: NHI:				
Sapı	opte	rin	lihydrochloride		
Re-a	ieiupe A	men i tes Presc	required after 1 month ick boxes where appropriate) ibed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health spital.		
and	(and	<u>Э</u>	Patient has phenylketonuria (PKU) and is pregnant or actively planning to become pregnant		
	and	C	Freatment with sapropterin is required to support management of PKU during pregnancy		
	and	\mathcal{L}	Sapropterin to be administered at doses no greater than a total daily dose of 20 mg/kg		
	and	\mathcal{I}	Sapropterin to be used alone or in combination with PKU dietary management		
	(ر 	Total treatment duration with sapropterin will not exceed 22 months for each pregnancy (includes time for planning and becoming pregnant) and treatment will be stopped after delivery		
and			ibed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health spital.		
and			Following the initial one-month approval, the patient has demonstrated an adequate response to a 2 to 4 week trial of sapropterin with a clinically appropriate reduction in phenylalanine levels to support management of PKU during pregnancy		
		or	On subsequent renewal applications, the patient has previously demonstrated response to treatment with sapropterin and maintained adequate phenylalanine levels to support management of PKU during pregnancy		
	and				
		or	Patient continues to be pregnant and treatment with sapropterin will not continue after delivery Patient is actively planning a pregnancy and this is the first renewal for treatment with sapropterin		
		or	Treatment with sapropterin is required for a second or subsequent pregnancy to support management of their PKU during pregnancy		
Sapropterin to be administered at doses no greater than a total daily dose of 20 mg/kg			Sapropterin to be administered at doses no greater than a total daily dose of 20 mg/kg		
	(and	C	Sapropterin to be used alone or in combination with PKU dietary management		
	(C	Total treatment duration with sapropterin will not exceed 22 months for each pregnancy (includes time for planning and becoming pregnant) and treatment will be stopped after delivery		

I confirm that the above details are correct:

Signed: Date:

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PRESCR	IBER	PATIENT:		
Name:		Name:		
Ward:		NHI:		
Carglun	nic Acid			
INITIATIO Prerequi	ON isites (tick box where appropriate)			
O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
and	O For the acute in-patient treatment of organic acidaemias as an alternative to haemofiltration			

May 2025

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Coenzyme Q10	
INITIATION Re-assessment required after 6 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a metabolic physician, or in accommod NZ Hospital. and The patient has a suspected inborn error of metabolism that may rescribed to the patient has a suspected inborn error of metabolism.	ordance with a protocol or guideline that has been endorsed by the Health spond to coenzyme Q10 supplementation
CONTINUATION Re-assessment required after 24 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a metabolic physician, or in accommod NZ Hospital. and The patient has a confirmed diagnosis of an inborn error of meand The treatment remains appropriate and the patient is benefiting	

PRES	CRIBER	PATIENT:
Name	:	Name:
Ward		NHI:
Ribo	flavin	
Re-a	ATION ssessment required after 6 months equisites (tick box where appropriate) Prescribed by, or recommended by a metabolic physician or neurolo by the Health NZ Hospital. The patient has a suspected inborn error of metabolism that may res	gist, or in accordance with a protocol or guideline that has been endorsed spond to riboflavin supplementation
Re-a	TINUATION ssessment required after 24 months equisites (tick boxes where appropriate) Prescribed by, or recommended by a metabolic physician or neurolo by the Health NZ Hospital.	gist, or in accordance with a protocol or guideline that has been endorsed
	The patient has a confirmed diagnosis of an inborn error of meand The treatment remains appropriate and the patient is benefiting	

I confirm that the above details are correct:	
Signed:	Date:

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PRES	CRIBER	PATIENT:
Name	:	Name:
Ward		NHI:
Taur	ne	
Re-a	ATION seessment required after 6 months equisites (tick box where appropriate) Prescribed by, or recommended by a metabolic physician, or in acconnounce NZ Hospital. The patient has a suspected specific mitochondrial disorder that may	rdance with a protocol or guideline that has been endorsed by the Health respond to taurine supplementation
Re-a	TINUATION seessment required after 24 months equisites (tick boxes where appropriate) Prescribed by, or recommended by a metabolic physician, or in acconditional NZ Hospital.	rdance with a protocol or guideline that has been endorsed by the Health
	The patient has a confirmed diagnosis of a specific mitochond and The treatment remains appropriate and the patient is benefitin	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Trientine	
and not received sufficient benefit Treatment with zinc has been trialled and discontinued becaus	see the person has experienced intolerable side effects or has see the person has experienced intolerable side effects or has not propriate as the person has symptomatic liver disease and requires

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	CRIBER	PATIENT:
Name	·	Name:
Ward:		NHI:
Сор	per chloride	
	ATION – Moderate to severe burns ssessment required after 3 months	
Prer	equisites (tick boxes where appropriate)	
	O Patient has been hospitalised with moderate to severe burns and	
	Treatment is recommended by a National Burns Unit specialis	st .

I confirm that the above details are correct:

0:	D - 1 - 1	
Zigneg.	i jate:	
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Page 35

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:	Name:
Ward:	NHI:
Ferric carboxymaltose	
INITIATION Prerequisites (tick box where appropriate)	
O Treatment with oral iron has proven ineffective or is clinically inappro	ppriate

I confirm that the above details are correct:

Signed: Date:

Page 36

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	CRIBER		PATIENT:
Name	e:		Name:
Ward	:		NHI:
Sele	nium		
		Moderate to severe burns nt required after 3 months	
Prer	equisites	(tick boxes where appropriate)	
	and	Patient has been hospitalised with moderate to severe burns	
		Treatment is recommended by a National Burns Unit specialist	t

I confirm that the above details are correct:

C:	D-1	
Signed.	Date:	
Oigilica.	 Daic.	

Form RS1175 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 37

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Sodium hyaluronate	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by an otolaryngologist, or in accord Hospital.	ance with a protocol or guideline that has been endorsed by the Health NZ

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	SCR	IBER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Mult	ivit	amir	s - Cap	
INITI Prer			(tick boxes where appropriate)	
		O	Patient has cystic fibrosis with pancreatic insufficiency	
	or	0	Patient is an infant or child with liver disease or short gut synd	rome
	or	0	Patient has severe malabsorption syndrome	

Form RS1178 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 39

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Multivitamins – Powder	
INITIATION Prerequisites (tick box where appropriate)	
O Patient has inborn errors of metabolism	

0:	D - 1 - 1	
Zigneg.	i jate:	
Oigilica.	 Duic.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Multivitamin and mineral supplement	
INITIATION Re-assessment required after 3 months Prerequisites (tick boxes where appropriate) Or Patient was admitted to hospital with burns and Or Burn size is greater than 15% of total body surface area or Or Burn size is greater than 10% of BSA for mid-dermal or or Or Nutritional status prior to admission or dietary intake is p	deep dermal burns

Page 41

PRE	SCR	IBER		PATIENT:
Nam	e:			Name:
Ward	l:			NHI:
Mult	ivit	amir	n renal	
INIT Prei			(tick boxes where appropriate)	
		0	The patient has chronic kidney disease and is receiving either	peritoneal dialysis or haemodialysis
	or	0	The patient has chronic kidney disease grade 5, defined as pa body surface area (BSA)	atient with an estimated glomerular filtration rate of < 15 ml/min/1.73m ²

May 2025

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.

PRESCR	RIBER		PATIENT:
Name: .	ame:		
Ward:			NHI:
Alpha t	oco	phery	yl acetate
		-	c fibrosis poxes where appropriate)
ar		Cyst	ic fibrosis patient
	O	, 0	Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck)
		0	The other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate for the patient
	isites	tick t	oradionecrosis cox where appropriate) atment of osteoradionecrosis
			indications poxes where appropriate)
ar	O	Infar	nt or child with liver disease or short gut syndrome
ar	0	Requ	uires vitamin supplementation
	O	, 0	Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplements (Vitabdeck)
		0	The other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate for patient

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:	Name:
Ward:	NHI:
Alpha tocopheryl	
INITIATION – Cystic fibrosis Prerequisites (tick boxes where appropriate)	
O Cystic fibrosis patient	
O Patient has tried and failed the othe	er available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck)
The other available funded fat solub	ole vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate for
INITIATION – Osteoradionecrosis Prerequisites (tick box where appropriate) Or For the treatment of osteoradionecrosis	
INITIATION – Other indications Prerequisites (tick boxes where appropriate)	
O Infant or child with liver disease or short g	nut syndrome
Requires vitamin supplementation	
	er available funded fat soluble vitamin A,D,E,K supplements (Vitabdeck)
The other available funded fat solub patient	ole vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate for

Blood and Blood Forming Organs



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	PA	ΓΙΕΝΤ:
Name:	Na	me:
Ward:	NH	l:
Epoetin beta	a	
	chronic renal failure s (tick boxes where appropriate)	
O	Patient in chronic renal failure	
and and	Haemoglobin is less than or equal to 100g/L	
	Patient does not have diabetes mellitus Glomerular filtration rate is less than or equal to 30ml/	min
or	Patient has diabetes mellitus and Glomerular filtration rate is less than or equal to 45ml/	
or	·	
Re-assessmer	myelodysplasia* nt required after 12 months s (tick boxes where appropriate)	
and	Patient has a confirmed diagnosis of myelodysplasia (MDS)	
and	Has had symptomatic anaemia with haemoglobin < 100g/L and is	red cell transfusion-dependent
0	Patient has very low, low or intermediate risk MDS based on the W syndrome (WPSS)	/HO classification-based prognostic scoring system for myelodysplastic
and	Other causes of anaemia such as B12 and folate deficiency have	peen excluded
and	Patient has a serum epoetin level of < 500 IU/L	
	The minimum necessary dose of epoetin would be used and will n	ot exceed 80,000 iu per week
Re-assessmer	ON – myelodysplasia* nt required after 2 months s (tick boxes where appropriate)	
and	The patient's transfusion requirement continues to be reduced with	epoetin treatment
and	Transformation to acute myeloid leukaemia has not occurred	
	The minimum necessary dose of epoetin would be used and will n	ot exceed 80,000 iu per week

I confirm that the above details are correct:

Signed: Date:

PRES	CRIBER		PATIENT:
Name	e:		Name:
Ward	:		NHI:
Epo	etin beta	a - continued	
		all other indications	
Prer	equisites	(tick boxes where appropriate)	
	0	Haematologist	
	and	For use in patients where blood transfusion is not a viable treat	utment alternative
	and	*Note: Indications marked with * are unapproved indications	

0:	D - 1 - 1	
Zigneg.	i jate:	
Oigilica.	 Duic.	

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:	Name:
Ward:	NHI:
Epoetin alfa	
	chronic renal failure (tick boxes where appropriate)
and O	Patient in chronic renal failure Haemoglobin is less than or equal to 100g/L
and	O Patient does not have diabetes mellitus and O Glomerular filtration rate is less than or equal to 30ml/min
or	Patient has diabetes mellitus Glomerular filtration rate is less than or equal to 45ml/min Patient is on haemodialysis or peritoneal dialysis
Re-assessmen	myelodysplasia* t required after 2 months (tick boxes where appropriate)
and	Patient has a confirmed diagnosis of myelodysplasia (MDS)
and	Has had symptomatic anaemia with haemoglobin < 100g/L and is red cell transfusion-dependent
and	Patient has very low, low or intermediate risk MDS based on the WHO classification-based prognostic scoring system for myelodysplastic syndrome (WPSS)
and	Other causes of anaemia such as B12 and folate deficiency have been excluded
and	Patient has a serum epoetin level of < 500 IU/L
O	The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week
Re-assessmen	ON – myelodysplasia* t required after 12 months (tick boxes where appropriate)
and	The patient's transfusion requirement continues to be reduced with epoetin treatment
and	Transformation to acute myeloid leukaemia has not occurred
	The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week

I confirm that the above details are correct:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Epoetin alfa - continued	
INITIATION – all other indications Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O For use in patients where blood transfusion is not a viable treatment alternative Note: Indications marked with * are unapproved indications	

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	SCRI	IBER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Apro	otin	in		
INIT Prer		isites Preso	(tick boxes where appropriate) cribed by, or recommended by a cardiac anaesthetist, or in accolospital.	ordance with a protocol or guideline that has been endorsed by the Health
	or	0	Paediatric patient undergoing cardiopulmonary bypass proced	
			Adult patient undergoing cardiac surgical procedure where the effects of the drug	significant risk of massive bleeding outweighs the potential adverse

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

May 2025

PRESCRIBER	PATIENT:	
Name:	Name:	
Vard: NHI:		
Eltrombopag		
INITIATION – idiopathic thrombocytopenic purpura - post-splenectomy Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a haematologist, or in accordance Hospital. Patient has had a splenectomy and Two immunosuppressive therapies have been trialled and failed and and Patient has a platelet count of 20,000 to 30,000 platelets or	s per microlitre and has evidence of significant mucocutaneous bleeding 00 platelets per microlitre and has evidence of active bleeding	
Tallette rias a platelet court of less than of equal to 10,0	So places per interest	
INITIATION – idiopathic thrombocytopenic purpura - preparation for splet Re-assessment required after 6 weeks Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a haematologist, or in accordance Hospital. and The patient requires eltrombopag treatment as preparation for spleness.	ee with a protocol or guideline that has been endorsed by the Health NZ	
CONTINUATION – idiopathic thrombocytopenic purpura - post-splenector Re-assessment required after 12 months Prerequisites (tick box where appropriate)	be with a protocol or guideline that has been endorsed by the Health NZ	
Hospital. and The patient has obtained a response (see Note) from treatment duri treatment is required Note: Response to treatment is defined as a platelet count of > 30,000 platelet	ng the initial approval or subsequent renewal periods and further	
INITIATION – idiopathic thrombocytopenic purpura contraindicated to special Re-assessment required after 3 months Prerequisites (tick boxes where appropriate) Or Prescribed by, or recommended by a haematologist, or in accordance Hospital.	blenectomy be with a protocol or guideline that has been endorsed by the Health NZ	
Patient has a significant and well-documented contraindication and Two immunosuppressive therapies have been trialled and faile and Patient has immune thrombocytopenic purpura* with a poor	' '	

May 2025

PRES	SCRIBER	PATIENT:
Name:		Name:
Ward		NHI:
Eltro	embopag - continued	
Re-a	TINUATION – idiopathic thrombocytopenic purpura contraindicated ssessment required after 12 months equisites (tick boxes where appropriate) Prescribed by, or recommended by a haematologist, or in accordance Hospital.	to splenectomy ce with a protocol or guideline that has been endorsed by the Health NZ
and	The patient's significant contraindication to splenectomy remainded. The patient has obtained a response from treatment during the and Patient has maintained a platelet count of at least 50,000 plate and	e initial approval period
	O Further treatment with eltrombopag is required to maintain res	ponse
Re-a	Hospital. Two immunosuppressive therapies have been trialled and failed and	
Re-a	Hospital.	be with a protocol or guideline that has been endorsed by the Health NZ at 20,000 platelets per microlitre above baseline during the initial approval during the initial approval period

I confirm that the above details are correct:	
Signed:	Date:

Form RS1500 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 52

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:	Name:
Ward:	NHI:
Aluminium chloride	
INITIATION Prerequisites (tick box where appropriate)	
O For use as a haemostatis agent	

I confirm that the above details are correct:

Page 53

PRES	CRIBER		PATIENT:
Name	e:		Name:
Ward	:		NHI:
Emi	cizumat)	
	equisites		e with a protocol or guideline that has been endorsed by the Health NZ
O Patient has severe congenital haemophilia A with a severe bleeding phenotype (endogenous factor VIII activity 2%)		eding phenotype (endogenous factor VIII activity less than or equal to	
	and	Emicizumab is to be administered at a dose of no greater than weekly	3 mg/kg weekly for 4 weeks followed by the equivalent of 1.5 mg/kg

I confirm that the above details are correct:	
Signod:	Date:

Form RS1535 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 54

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Idarucizumab		
INITIATION		
Prerequisites (tick box where appropriate)		
O For the reversal of the anticoagulant effects of dabigatran when required in situations of life-threatening or uncontrolled bleeding, or for emergency surgery or urgent procedures		

Form RS1706 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 55

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:	Name:	
Ward:	NHI:	
Moroctocog alfa [Recombinant factor VIII]		
INITIATION Prerequisites (tick box where appropriate)		
O For patients with haemophilia. Rare Clinical Circumstances Brand of short half-life recombinant factor VIII. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group, subject to criteria		

Form RS1707 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 56

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.

PRESCRIBE	R	PATIENT:
Name:		Name:
Ward:		NHI:
Octocog alfa [Recombinant factor VIII] (Advate)		
INITIATION Prerequisites (tick box where appropriate)		
O For patients with haemophilia. Preferred Brand of short half-life recombinant factor VIII. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group		

Form RS1708 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 57

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Octocog alfa [Recombinant factor VIII] (Kogenate FS) INITIATION Prerequisites (tick box where appropriate)	
O For patients with haemophilia. Rare Clinical Circumstances Brand of short half-life recombinant factor VIII. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group, subject to criteria	

Form RS1679 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 58

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:	Name:	
Ward:	NHI:	
Nonacog gamma		
INITIATION Prerequisites (tick box where appropriate)		
For patients with haemophilia. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group		

Form RS1682 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 59

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:	Name:	
Ward:	NHI:	
Rurioctocog alfa pegol [Recombinant factor VIII]		
INITIATION Prerequisites (tick box where appropriate)		
O For patients with haemophilia A receiving prophylaxis treatment. A in conjunction with the National Haemophilia Management Group	ccess to funded treatment is managed by the Haemophilia Treaters Group	

Form RS1684 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 60

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Eftrenonacog alfa	
INITIATION	
Prerequisites (tick box where appropriate)	
O For patients with haemophilia B receiving prophylaxis treatment. Ac in conjunction with the National Haemophilia Management Group	cess to funded treatment is managed by the Haemophilia Treaters Group

Form RS1705 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 61

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Factor eight inhibitor bypassing fraction		
INITIATION		
Prerequisites (tick box where appropriate)		
O For patients with haemophilia. Preferred Brand of bypassing agent for > 14 days predicted use. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group		

Form RS1704 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Eptacog alfa		
INITIATION Prerequisites (tick box where appropriate)		
O For patients with haemophilia. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group. Rare Clinical Circumstances Brand of bypassing agent for > 14 days predicted use. Access to funded treatment for > 14 days predicted use is by named patient application to the Haemophilia Treaters Group, subject to access criteria		

Page 63

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	CR	BER	PATIENT:
Name:			Name:
Ward:			NHI:
Biva	liru	din	
INITI Prer		ON sites (tick boxes where appropriate)	
	O For use in heparin-induced thrombocytopaenia, heparin resistance or heparin intolerance		
	or	O For use in patients undergoing endovascular procedures	

I confirm that the above details are correct:

Signed: Date:

Form RS1182 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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.

PATIENT:
Name:
NHI:
or heparin intolerance

I confirm that the above details are correct:

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Signed.	Date:	
Oigilica.	 Daic.	

Form RS1183 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 65

PRESCRIBER		PATIENT:	
Name:		Name:	
Ward:		NHI:	
Defibro	tide		
INITIATION Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
and	Patient has moderate or severe sinusoidal obstruction syndrome as	a result of chemotherapy or regimen-related toxicities	

Form RS1184 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 66

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:	Name:		
Ward:	NHI:		
Fondaparinux sodium			
INITIATION Prerequisites (tick box where appropriate)			
O For use in heparin-induced thrombocytopaenia, heparin resistance of	or heparin intolerance		

I confirm that the above details are correct:

PRES	CRIBER		PATIENT:
Name	e:		Name:
Ward	:		NHI:
Lysi	ne acety	/Isalicylate	
	ATION equisites	(tick boxes where appropriate)	
	and	For use when an immediate antiplatelet effect is required prior procedure	to an urgent interventional neuro-radiology or interventional cardiology
		Administration of oral aspirin would delay the procedure	

May 2025

PRES	CRI	BER		PATIENT:
Name	e:			Name:
Ward:	:			NHI:
Eptif	iba	tide		
INITI Prere			(tick boxes where appropriate)	
		O	For use in patients with acute coronary syndromes undergoing	percutaneous coronary intervention
	or	0	For use in patients with definite or strongly suspected intra-cor	onary thrombus on coronary angiography
O For use in patients			For use in patients undergoing intra-cranial intervention	

May 2025

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.

PRESCRI	BER	PATIENT:
Name:		Name:
Ward:		NHI:
Ticagre	lor	
0	Rest	(tick box where appropriate) ricted to treatment of acute coronary syndromes specifically for patients who have recently (within the last 60 days) been diagnosed with T-elevation or a non-ST-elevation acute coronary syndrome, and in whom fibrinolytic therapy has not been given in the last 24 hours and it planned
Re-asses	ssmer	thrombosis prevention neurological stenting at required after 12 months (tick boxes where appropriate)
and	or	O Patient has had a neurological stenting procedure* in the last 60 days O Patient is about to have a neurological stenting procedure performed*
and	or	O Patient has demonstrated clopidogrel resistance using the P2Y12 (VerifyNow) assay or another appropriate platelet function assay and requires antiplatelet treatment with ticagrelor O Clopidogrel resistance has been demonstrated by the occurrence of a new cerebral ischemic event O Clopidogrel resistance has been demonstrated by the occurrence of transient ischemic attack symptoms referable to the stent.
Re-asses	sites	DN – thrombosis prevention neurological stenting at required after 12 months (tick boxes where appropriate) Patient is continuing to benefit from treatment Treatment continues to be clinically appropriate
Re-asses	ssmer	Percutaneous coronary intervention with stent deployment at required after 12 months (tick boxes where appropriate)
and	0	Patient has undergone percutaneous coronary intervention Patient has had a stent deployed in the previous 4 weeks Patient is clopidogrel-allergic**
Prerequi	sites	Stent thrombosis (tick box where appropriate) nt has experienced cardiac stent thrombosis whilst on clopidogrel
INITIATION Re-asses	ON – ssmer	Myocardial infarction It required after 1 week (tick box where appropriate) hort term use while in hospital following ST-elevated myocardial infarction
Loonfirm th	aat th	e above details are correct.

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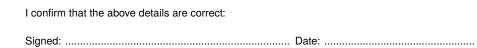
Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to Section H of the Pharmaceutical Schedule. For community funding, see the Special Authority Criteria.

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		

Ticagrelor - continued

Note: Indications marked with * are unapproved indications.

Note: Note: ** Clopidogrel allergy is defined as a history of anaphylaxis, urticaria, generalised rash or asthma (in non-asthmatic patients) developing soon after clopidogrel is started and is considered unlikely to be caused by any other treatment



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.

RESCRIBER	PATIENT:
me:	Name:
ırd:	NHI:
erixafor	
and	stem cell transplantation previous unsuccessful mobilisation attempt with plerixafor
and O Has treat	undergoing G-CSF mobilisation a suboptimal peripheral blood CD34 count of less than or equal to 10 × 10 ⁶ /L on day 5 after 4 days of G-CSF tment orts to collect > 1 × 10 ⁶ CD34 cells/kg have failed after one apheresis procedure
and O and O	undergoing chemotherapy and G-CSF mobilisation Has rising white blood cell counts of > 5 × 10 ⁹ /L Has a suboptimal peripheral blood CD34 count of less than or equal to 10 × 10 ⁶ /L erts to collect > 1 × 10 ⁶ CD34 cells/kg have failed after one apheresis procedure
or	peripheral blood CD34 cell counts are decreasing before the target has been received illisation attempt with G-CSF or G-CSF plus chemotherapy has failed

I confirm that the above details are correct:

Prerequisites (tick box where appropriate) Or For prevention of neutropenia in patients undergoing high risk chemotherapy for cancer (febrile neutropenia risk greater than or equal to 5%* Note: *Febrile neutropenia risk greater than or equal to 5% after taking into account other risk factors as defined by the European Organisation for	PRESCRIBER	PATIENT:
egfilgrastim NITIATION Prerequisites (tick box where appropriate) For prevention of neutropenia in patients undergoing high risk chemotherapy for cancer (febrile neutropenia risk greater than or equal to 5%* Note: *Febrile neutropenia risk greater than or equal to 5% after taking into account other risk factors as defined by the European Organisation for	Name:	Name:
NITIATION Prerequisites (tick box where appropriate) For prevention of neutropenia in patients undergoing high risk chemotherapy for cancer (febrile neutropenia risk greater than or equal to 5%* Note: *Febrile neutropenia risk greater than or equal to 5% after taking into account other risk factors as defined by the European Organisation for	Vard:	NHI:
Prerequisites (tick box where appropriate) O For prevention of neutropenia in patients undergoing high risk chemotherapy for cancer (febrile neutropenia risk greater than or equal to 5%* Note: *Febrile neutropenia risk greater than or equal to 5% after taking into account other risk factors as defined by the European Organisation for	Pegfilgrastim	
Note: *Febrile neutropenia risk greater than or equal to 5% after taking into account other risk factors as defined by the European Organisation for	INITIATION Prerequisites (tick box where appropriate)	

I confirm that the above details are correct:

C:	D-1	
Signed.	Date:	
Oigilica.	 Daic.	

Form RS1188 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

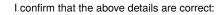
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PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Filgrastim				
INITIATION				
Prerequisites (tick box where appropriate)				
O Prescribed by, or recommended by a haematologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				

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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:	Name:
Ward:	NHI:
Sodium chloride – Inj	
INITIATION Prerequisites (tick box where appropriate)	
O For use in flushing of in-situ vascular access devices only	



Signed: Date:

Cardiovascular System



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	SCR	IBER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Capt	top	ril - C	Oral liq 5 mg per ml	
INITI Prer			(tick boxes where appropriate)	
		0	For use in children under 12 years of age	
	or	\circ	For use in tube-fed patients	
	or	\circ	For management of rebound transient hypertension following	cardiac surgery

 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:	Name:
Ward:	NHI:
Sacubitril with valsartan	
INITIATION Prerequisites (tick boxes where appropriate)	
Patient has heart failure	
O Patient is in NYHA/WHO functional class II	
O Patient is in NYHA/WHO functional class III	
O Patient is in NYHA/WHO functional class IV	
and	
Patient has a documented left ventricular ejection fraction	on (LVEF) of less than or equal to 35%
An ECHO is not reasonably practical, and in the opinion	of the treating practitioner the patient would benefit from treatment
O Patient is receiving concomitant optimal standard chronic hea	rt failure treatments

I confirm that the above details are correct:

Signed: Date:

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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:	Name:
Ward:	NHI:
Adenosine - Inj 3 mg per ml, 10 ml vial	
INITIATION Prerequisites (tick box where appropriate)	
O For use in cardiac catheterisation, electrophysiology and MRI	

I confirm that the above details are correct:

Signed: Date:

Form RS1001 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 79

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Ajmaline	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a cardiologist, of Hospital.	or in accordance with a protocol or guideline that has been endorsed by the Health NZ

I confirm that the above details are correct:		
Signed:	Data:	

May 2025

PRESCRI	BER		PATIENT:
Name:			Name:
Ward:			NHI:
lvabradi	ine		
INITIATIO Prerequis		(tick boxes where appropriate)	
and	O _	Patient is indicated for computed tomography coronary angiog	raphy
		O Patient has a heart rate of greater than 70 beats per min	ute while taking a maximally tolerated dose of beta blocker
	or	O Patient is unable to tolerate beta blockers	

Form RS1427 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 81

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:	Name:
Ward:	NHI:
Midodrine	
INITIATION Prerequisites (tick box where appropriate)	
O Patient has disabling orthostatic hypotension not due to drugs	

I confirm that the above details are correct:

Signed: Date:

PRES	CRI	BER		PATIENT:
Name	e:			Name:
Ward	·			NHI:
Nica	rdip	oine	hydrochloride	
INITI Prere	equi	sites Pres	cribed by, or recommended by an anaesthetist, intensivist, cardieline that has been endorsed by the Health NZ Hospital.	ologist or paediatric cardiologist, or in accordance with a protocol or
	or	O O	Patient has hypertension requiring urgent treatment with an interpretation Patient has excessive ventricular afterload	ravenous agent
	or	0	Patient is awaiting or undergoing cardiac surgery using cardio	pulmonary bypass

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	CRIE	BER		PATIENT:
Name	:			Name:
Ward:				NHI:
Eple	reno	ne		
INITI. Prere			(tick boxes where appropriate)	
	and	0	Patient has heart failure with ejection fraction less than 40%	
		or	O Patient is intolerant to optimal dosing of spironolactone	
		J	O Patient has experienced a clinically significant adverse e	effect while on optimal dosing of spironolactone

Signed: Date:

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	9:	Name:
Ward	:	NHI:
Tolv	aptan	
Re-a	with a protocol or guideline that has been endorsed by the Health Na Patient has a confirmed diagnosis of autosomal dominant poly and Patient has an estimated glomerular filtration rate (eGFR) of g and Patient's disease is rapidly progressing, with a decline in	·
	year over a five-year period	resource in early of greater than or equal to 2.6 million with a por
Re-a	ITINUATION – autosomal dominant polycystic kidney disease issessment required after 12 months equisites (tick boxes where appropriate)	
and	Prescribed by, or recommended by a renal physician or any relevant with a protocol or guideline that has been endorsed by the Health Na	practitioner on the recommendation of a renal physician, or in accordance Z Hospital.
	O Patient has not developed end-stage renal disease, defined as and O Patient has not undergone a kidney transplant	s an eGFR of less than 15 mL/min/1.73 m ²

I confirm that the above details are correct:

0:	D - 1 - 1	
Zigneg.	i jate:	
Oigilica.	 Duic.	

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:		Name:
Ward:		NHI:
Rosuvastatin		
	rdiovascular disease risk ck boxes where appropriate)	
or and	Patient is considered to be at risk of cardiovascular disease Patient is Māori or any Pacific ethnicity Patient has a calculated risk of cardiovascular disease of LDL cholesterol has not reduced to less than 1.8 mmol/li and/or simvastatin	
	milial hypercholesterolemia ck boxes where appropriate)	
Patient has familial hypercholesterolemia (defined as a Dutch Lipid Criteria score greater than or equal to 6) and LDL cholesterol has not reduced to less than 1.8 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or simvastatin		
	tablished cardiovascular disease ck boxes where appropriate)	
or (Patient has proven coronary artery disease (CAD) Patient has proven peripheral artery disease (PAD) Patient has experienced an ischaemic stroke	
	DL cholesterol has not reduced to less than 1.4 mmol/litre wit imvastatin	h treatment with the maximum tolerated dose of atorvastatin and/or
	current major cardiovascular events ck boxes where appropriate)	
and re	evascularisation, hospitalisation for unstable angina) in the las	t (defined as myocardial infarction, ischaemic stroke, coronary t 2 years h treatment with the maximum tolerated dose of atorvastatin and/or

I confirm that the above details are correct:

Signed: Date:

PRESCR	IBER	PATIENT:			
Name:		Name:			
Ward:		NHI:			
Levosin	nendan				
	ON – Heart transplant isites (tick boxes where appropriate)				
or	Or For use as a bridge to heart transplant, in patients who have been accepted for transplant Or For the treatment of heart failure following heart transplant				
INITIATIO	ON – Heart failure				
Prerequisites (tick box where appropriate)					
and	Prescribed by, or recommended by a cardiologist or intensivist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
	For the treatment of severe acute decompensated heart failure that is non-responsive to dobutamine				

Form RS1992 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 87

PRES	CRIBER		PATIENT:
Name:			Name:
Ward:			NHI:
Alpr	ostadil		
	ATION equisites	(tick boxes where appropriate)	
	O	Patient has erectile dysfunction	
	and	Patient is to receive a penile Doppler ultrasonography	

C:	D-1	
Signed.	Date:	
Oigilica.	 Daic.	

Page 88

PRESCRIBER				PATIENT:
Name:				Name:
Ward:				NHI:
Hyd	rala	zine	hydrochloride - Tab 25 mg	
INIT Prer			(tick boxes where appropriate)	
		0	For the treatment of refractory hypertension	
	or	0	For the treatment of heart failure, in combination with a nitrate and/or angiotensin receptor blockers	, in patients who are intolerant or have not responded to ACE inhibitors

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.

Nard: Dosentan INITIATION – P Re-assessment Prerequisites (Name: NHI: PAH monotherapy It required after 6 months (tick boxes where appropriate) Cribed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of piratory specialist, cardiologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ item.
INITIATION – P Re-assessment Prerequisites (PAH monotherapy It required after 6 months (tick boxes where appropriate) cribed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of piratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
INITIATION – P Re-assessment Prerequisites (trequired after 6 months (tick boxes where appropriate) cribed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of piratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
Re-assessment Prerequisites (trequired after 6 months (tick boxes where appropriate) cribed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of piratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and	Patient has pulmonary arterial hypertension (PAH)* PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV PAH has been confirmed by right heart catheterisation and A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair) A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg and Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm 5) and PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) † Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool** Patient has PAH other than idiopathic / heritable or drug-associated type
and	disorders including severe chronic neonatal lung disease Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures Bosentan is to be used as PAH monotherapy Patient has experienced intolerable side effects on sildenafil Patient has an absolute contraindication to sildenafil
	O Patient is a child with idiopathic PAH or PAH secondary to congenital heart disease

I confirm that the above details are correct:

O'	D - 4
Signed.	Date.
OIGHICG:	

PRESC	RESCRIBER PATIENT:				
Name: Name:					
Ward: .	rd:NHI:				
osen	tan	- CO	ntinue	d .	
Re-ass	essn	nent i	require	al therapy ed after 6 months ees where appropriate)	
and	a ı		ratory	or, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ	
а	nd _) _F	Patient	has pulmonary arterial hypertension (PAH)*	
а	nd () _F	PAH is	in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications	
	nd () F	PAH is	in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV	
			and and and	PAH has been confirmed by right heart catheterisation A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair) A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵) PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) † Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool** Patient has PAH other than idiopathic / heritable or drug-associated type	
		or or	о О ғ	Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung isorders including severe chronic neonatal lung disease Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the contan circulation requiring the minimising of pulmonary/venous filling pressures	
а	Bosentan is to be used as part of PAH dual therapy				
			or	Patient has tried a PAH monotherapy (sildenafil) for at least three months and has experienced an inadequate therapeutic response to treatment according to a validated risk stratification tool** Patient is presenting in NYHA/WHO functional class III or IV, and in the opinion of the treating clinician would likely benefit from initial dual therapy	

I confirm that the above details are correct:	
Signed:	Date:

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.

SCRIBER	PATIENT:
e:	Name:
l:	NHI:
entan - continue	ed
requisites (tick both	ple therapy red after 6 months exes where appropriate) exp, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation or specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health Na
and	t has pulmonary arterial hypertension (PAH)*
and	s in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications s in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
and and and	A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair) A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵)
or O	Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures Bosentan is to be used as part of PAH triple therapy Patient is on the lung transplant list Patient is presenting in NYHA/WHO functional class IV Patient has tried PAH dual therapy for at least three months and has not experienced an acceptable response to treatment according to a validated risk stratification tool** Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario

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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.

PRESCR	IBER	PATIENT:
Name:		Name:
Ward:		NHI:
bosenta	an - continued	
	IUATION ssment required after 2 years iisites (tick box where appropriate)	
and		gist, rheumatologist or any relevant practitioner on the recommendation of nice with a protocol or guideline that has been endorsed by the Health NZ rding to a validated PAH risk stratification tool**

Note: † The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the

diagnosis and treatment of pulmonary hypertension PAH

** the requirement to use a validated risk stratification tool to determine insufficient response applies to adults.

Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

I confirm that the above details are correct: Signed: Date:

PRESCRIBER		PATIENT:
Name:		Name:
Ward:		NHI:
Ambriser	ntan	
Prerequisi Prerequisi A A A A A A A A A A A A A A A A A A	ment rec i tes (tick rescribe	monotherapy quired after 6 months boxes where appropriate) d by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of bory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and (and (and ()	D PAH	ient has pulmonary arterial hypertension (PAH) H is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications H is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
and	a	PAH has been confirmed by right heart catheterisation A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair) A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵) PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) † Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool** Patient has PAH other than idiopathic / heritable or drug-associated type Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures
and	and	O Patient has an absolute contraindication to sildenafil and an absolute or relative contraindication to bosentan (e.g. due to current use of a combined oral contraceptive or liver disease)

I confirm that the above details are correct:	
Signed:	Date:

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.

SCRIBER		PATIENT:	
e:		Name:	
:		NHI:	
orisentai	1 - con	ntinued	
assessmen requisites Preso	t requir (tick bo cribed b oiratory	red after 6 months expected af	
O	Patien	it has pulmonary arterial hypertension (PAH)	
and and		s in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications s in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV	
and		O PAH has been confirmed by right heart catheterisation	
	and	· ·	
	and	A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg	
Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵)			
PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric or defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †			
		O Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**	
		O Patient has PAH other than idiopathic / heritable or drug-associated type	
or		Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease	
		Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures	
and	\bigcirc	Ambrisentan is to be used as PAH dual therapy	
an	_	O Patient has tried a PAH monotherapy (sildenafil or bosentan) for at least three months and has not experienced an	
	or	acceptable response to treatment according to a validated risk stratification tool**	
an	d _	O Patient has tried PAH dual therapy including bosentan and has experienced intolerable side effects on bosentan	
	and	O Patient is presenting in NYHA/WHO functional class III or IV, and in the opinion of the treating clinician would benefit from initial dual therapy	
	and	Patient has an absolute or relative contraindication to bosentan (eg due to current use of a combined oral contraceptive or liver disease)	

I confirm that the above details are correct:

Signed: Date:

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.

SCRIBER		PATIENT:
e:		Name:
:		NHI:
risentan	I - continued	
assessment requisites (t		st, rheumatologist or any relevant practitioner on the recommendation of ce with a protocol or guideline that has been endorsed by the Health NZ
Hospita		te with a protocor of guideline that has been endorsed by the riealin 192
and F	Patient has pulmonary arterial hypertension (PAH) PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical cla	ssifications
and and	PAH is in New York Heart Association/World Health Organization	on (NYHA/WHO) functional class II, III or IV
	PAH has been confirmed by right heart catheterisat	
	A mean pulmonary artery pressure (PAPm) greater	than 20 mmHg (unless peri Fontan repair)
	A pulmonary capillary wedge pressure (PCWP) les	s than or equal to 15 mmHg
	O Pulmonary vascular resistance greater than 2 Wood and	d Units or greater than 160 International Units (dyn s cm ⁻⁵)
		onsive in vasoreactivity assessment using iloprost or nitric oxide, as PAH (see note below for link to these guidelines) †
		esponse to calcium antagonist treatment, according to a validated
	O Patient has PAH other than idiopathic / herita	ble or drug-associated type
or	disorders including chronic neonatal lung disease	disease or PAH due to idiopathic, congenital or developmental lung ease and elevated pulmonary pressures or a major complication of the venous filling pressures
and	Ambrisentan is to be used as PAH triple therapy	
	O Patient is on the lung transplant list or	
	O Patient is presenting in NYHA/WHO functions and	al class IV
	contraceptive or liver disease)	cation to bosentan (e.g. due to current use of a combined oral
	according to a validated risk stratification tool	t three months and remains in an unacceptable risk category **
	Patient does not have major life-threatening of	comorbidities and triple therapy is not being used in a palliative

I confirm that the above details are correct:

Signed: Date:

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:		Name:
Ward:		NHI:
Ambris	entan - continued	
Re-asse	IUATION ssment required after 2 years ilisites (tick box where appropriate)	
and _		gist, rheumatologist or any relevant practitioner on the recommendation of nce with a protocol or guideline that has been endorsed by the Health NZ
0	The patient is continuing to derive benefit from ambrisentan treatme	nt according to a validated PAH risk stratification tool**

Note: † The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the

diagnosis and treatment of pulmonary hypertension PAH

** the requirement to use a validated risk stratification tool to determine insufficient response applies to adults.

Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

I confirm that the above details are correct: Signed: Date:

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:	
ame: Name:		
Ward:	NHI:	
sildenafil (Vedafil)		
INITIATION – tablets Raynaud's Phenomenon Prerequisites (tick boxes where appropriate)		
digital ulcers; or gangrene) and Patient is following lifestyle management (proper b of sympathomimetic drugs) and	evere pain requiring hospital admission or with a high likelihood of digital ulceration; body insulation, avoidance of cold exposure, smoking cessation support, avoidance eatment with calcium channel blockers and nitrates (unless contraindicated or not	
	ist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of r in accordance with a protocol or guideline that has been endorsed by the Health NZ	
PAH is confirmed by right heart cathete and A mean pulmonary artery pressure (PA and A pulmonary capillary wedge pressure and Pulmonary vascular resistance (PVR) and PAH is non-responsive in vasore Guidelines for PAH (see note bel or Patient has not experienced an a risk stratification tool** Patient has PAH other than idiop or Patient is a child with PAH secondary to cong disorders including severe chronic neonatal in	3) clinical classifications th Organization (NYHA/WHO) functional class II, III or IV erisation APm) of greater than 20 mmHg e (PCWP) that is less than or equal to 15 mmHg of at least 2 Wood Units or at least 160 International Units (dyn s cm ⁻⁵) exactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS elow for link to these guidelines) † acceptable response to calcium antagonist treatment, according to a validated eathic / heritable or drug-associated type genital heart disease or PAH due to idiopathic, congenital or developmental lung lung disease ital heart disease and elevated pulmonary pressures or a major complication of the	

I confirm that the above details are correct:

Signed: Date:

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:
silder	nafil	(Ve	edafil) - continued
			ablets other conditions
Prere	quisi	tes	(tick boxes where appropriate)
	or (or (or ())))	For use in weaning patients from inhaled nitric oxide For perioperative use in cardiac surgery patients For use in intensive care as an alternative to nitric oxide For use in the treatment of erectile dysfunction secondary to spinal cord injury in patients being treated in a spinal unit
			njection (tick boxes where appropriate)
For use in the treatment of pulmonary hypertension in infants or children being treated in paediatric intensive care units and n intensive care units when the enteral route is not accessible		For use in the treatment of pulmonary hypertension in infants or children being treated in paediatric intensive care units and neonatal intensive care units when the enteral route is not accessible	
		or	O For perioperative use following cardiac surgery
		or	O For use in persistent pulmonary hypertension of the newborn (PPHN)
		UI.	O For use in congenital diaphragmatic hernia

Note: † The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the

diagnosis and treatment of pulmonary hypertension PAH

** the requirement to use a validated risk stratification tool to determine insufficient response applies to adults.

Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

I confirm that the above details are correct:		
Signed:	Date:	

PRESCRIBER	PATIENT:
Name:	
Ward:	NHI:
Epoprostenol	
INITIATION – PAH dual the Re-assessment required a Prerequisites (tick boxes	ofter 6 months
	r recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of ecialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
	s pulmonary arterial hypertension (PAH)
O PAH is in 0	Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications
PAH is in N	New York Heart Association/World Health Organization (NYHA/WHO) functional class III or IV
or disor	O Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**
and Patie	constenol is to be used as part of PAH dual therapy with either sildenafil or an endothelin receptor antagonist ent is presenting in NYHA/WHO functional class IV ent has tried a PAH monotherapy for at least three months and remains in an unacceptable risk category according to a lated risk stratification tool

I confirm that the above details are correct:		
Signed:	Date:	

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.

SCRIBER	PATIENT:
э:	Name:
!	NHI:
prostenol - co	ntinued
requisites (tick bo	ple therapy red after 6 months exes where appropriate) by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health Na
and	t has pulmonary arterial hypertension (PAH)
PAH is	s in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications
O PAH is	s in New York Heart Association/World Health Organization (NYHA/WHO) functional class III or IV
and	O PAH has been confirmed by right heart catheterisation
and	A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)
and	A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg
and	A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵)
	PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †
	Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**
	O Patient has PAH other than idiopathic / heritable or drug-associated type
or	Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the
	Fontan circulation requiring the minimising of pulmonary/venous filling pressures
and and	Epoprostenol is to be used as PAH triple therapy
or	O Patient is on the lung transplant list O Patient is presenting in NYHA/WHO functional class IV
or	Patient has tried PAH dual therapy for at least three months and has not experienced an acceptable response to treatment according to a validated risk stratification tool
	O Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative

 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:		Name:
Ward:		NHI:
Epoprostenol - continued		
CONTINUATION Re-assessment required after 2 Prerequisites (tick box where a		
a respiratory specialist Hospital.	, cardiologist or rheumatologist, or in accorda	gist, rheumatologist or any relevant practitioner on the recommendation of nee with a protocol or guideline that has been endorsed by the Health NZ
Patient is continuing to	derive benefit from epoprosterioi treatment a	according to a validated PAH risk stratification tool
Note: + The European Despir	story lournal Guidalines can be found here:	2022 ECC/EDC Guidolings for the

Note: † The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the diagnosis and treatment of pulmonary hypertension PAH

** the requirement to use a validated risk stratification tool to determine insufficient response applies to adults.

** the requirement to use a validated risk stratification tool to determine insufficient response applies to adults. Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

PRESCRIBER	PATIENT:
Name:	Name:
Nard:	NHI:
loprost	
a respiratory specialist, cardiologist or rheumatologist, or in a Hospital.	ardiologist, rheumatologist or any relevant practitioner on the recommendation of ccordance with a protocol or guideline that has been endorsed by the Health NZ
Patient has pulmonary arterial hypertension (PAH) and PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clin and PAH is in New York Heart Association/World Health Organd	
and A pulmonary capillary wedge pressure (PC and A pulmonary vascular resistance greater th and PAH has been demonstrated to be no defined in the 2022 ECS/ERS Guidel	greater than 20 mmHg (unless peri Fontan repair) WP) less than or equal to 15 mmHg and 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵) on-responsive in vasoreactivity assessment using iloprost or nitric oxide, as lines for PAH (see note below for link to these guidelines) † ptable response to calcium antagonist treatment, according to a validated
or disorders including severe chronic neonatal lung	eart disease and elevated pulmonary pressures or a major complication of the
and O	fects on sildenafil and both the funded endothelin receptor antagonists (i.e. sildenafil and an absolute or relative contraindication to endothelin receptor

I confirm that the above details are correct:	
Signed:	Date:

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.

SCRIBER	PATIENT:	
ə:		
l:	NHI:	
rost - con	ntinued	
assessment	PAH dual therapy t required after 6 months (tick boxes where appropriate)	
	cribed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation opiratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health Nital.	
and	Patient has pulmonary arterial hypertension (PAH)	
and	PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV	
and	O PAH has been confirmed by right heart catheterisation and	
	A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)	
	O A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg	
A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵)		
	PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †	
	O Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**	
	O Patient has PAH other than idiopathic / heritable or drug-associated type	
or	O Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease	
	O Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures	
and	O lloprost is to be used as PAH dual therapy with either sildenafil or an endothelin receptor antagonist	
	O Patient has an absolute contraindication to or has experienced intolerable side effects on sildenafil or	
	Patient has an absolute or relative contraindication to or experienced intolerable side effects with a funded endothelin receptor antagonist	
and		
	Patient has tried a PAH monotherapy for at least three months and remains in an unacceptable risk category according to a validated risk stratification tool**	
	Patient is presenting in NYHA/WHO functional class III or IV, and in the opinion of the treating clinician would benefit from initial dual therapy	

I confirm that the above details are correct:

Signed: Date:

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.

SCRIBER	PATIENT:
e:	
l:	NHI:
rost - continued	
Patien PAH tri assessment requir requisites (tick bo Prescribed book a respiratory Hospital. Patien and PAH is	ple therapy red after 6 months oxes where appropriate) by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health No at has pulmonary arterial hypertension (PAH) is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV PAH has been confirmed by right heart catheterisation A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair) A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg
or	PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) † Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool** Patient has PAH other than idiopathic / heritable or drug-associated type Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung
or O	disorders including severe chronic neonatal lung disease Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures Iloprost is to be used as PAH triple therapy
or	Patient is on the lung transplant list Patient is presenting in NYHA/WHO functional class IV Patient has tried PAH dual therapy for at least three months and has not experienced an acceptable response to treatment according to a validated risk stratification tool** Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario

I confirm that the above details are correct:

Signed: Date:

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PRESCR	IBER	PATIENT:	
Name:		Name:	
Ward:		NHI:	
lloprost	lloprost - continued		
	UATION ssment required after 2 years isites (tick box where appropriate)		
and	Prescribed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. Patient is continuing to derive benefit from iloprost treatment according to a validated PAH risk stratification tool		

Note: † The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the

diagnosis and treatment of pulmonary hypertension PAH

** the requirement to use a validated risk stratification tool to determine insufficient response applies to adults.

Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

I confirm that the above details are correct: Signed: Date:

Dermatologicals



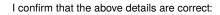
Form RS1299 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 107

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:	Name:
Ward:	NHI:
Mafenide acetate	
INITIATION Prerequisites (tick box where appropriate)	
O For the treatment of burns patients	



Signed: Date:

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	9:	Name:
Ward:		NHI:
Beta	methasone valerate with clioquinol	
	ATION equisites (tick boxes where appropriate)	
	O For the treatment of intertrigo	
	O For continuation use	

I confirm that the above details are correct:

Signed: Date:

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	:			Name:	
Ward:				NHI:	
Pime	croli	imu	ıs		
INITIATION Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a dermatologist, paediatrician or cendorsed by the Health NZ Hospital.			cribed by, or recommended by a dermatologist, paediatrician or	ophthalmologist, or in accordance with a protocol or guideline that has been	
	Patient has atopic dermatitis on the eyelid Patient has at least one of the following contraindications to topical corticosteroids: periorificial dermatitis, rosacea, documented epidermal atrophy, documented allergy to topical corticosteroids, cataracts, glaucoma, or raised intraocular pressure				

PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Tacrolimus Ointment				
INITIATION Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a dermatologist or paediatrician, Health NZ Hospital.	or in accordance with a protocol or guideline that has been endorsed by the			
Patient has atopic dermatitis on the face and Patient has at least one of the following contraindications to topical corticosteroids: periorificial dermatitis, rosacea, documented epidermal atrophy or documented allergy to topical corticosteroids				

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Methyl aminolevulinate hydrochloride				
INITIATION Prerequisites (tick box where appropriate)				
O Prescribed by, or recommended by a dermatologist or plastic surgeon, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				

Genito-Urinary System



Form RS1130 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 113

	PRESCR	IBER	PATIENT:			
	Name:		Name:			
Ward:			NHI:			
	Terbuta	line				
1	INITIATION					
	Prerequ	isites (tick box where appropriate)				
	O Prescribed by, or recommended by an obstetrician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.					

PRES	CRIB	ER		PATIENT:
Name	:			Name:
Ward:				NHI:
Fina	steri	de		
INITIATION Prerequisites (tick boxes where appropriate)			(tick boxes where appropriate)	
	and	С	Patient has symptomatic benign prostatic hyperplasia	
		or	O The patient is intolerant of non-selective alpha blockers	or these are contraindicated
			O Symptoms are not adequately controlled with non-select	tive alpha blockers

PRES	SCRIBER	PATIENT:		
Name	Đ:	Name:		
Ward	t	NHI:		
Tam	sulosin			
INITIATION Prerequisites (tick boxes where appropriate)				
	O Patient has symptomatic benign prostatic hyperplasia and			
	The patient is intolerant of non-selective alpha blockers	or these are contraindicated		

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Potassium citrate			
INITIATION Prerequisites (tick boxes where appropriate)			
The patient has recurrent calcium oxalate urolithiasis			
The patient has had more than two renal calculi in the two year	ars prior to the application		

I confirm that the above details are correct:

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Zigneg.	i jate:	
Oigilica.	 Duic.	

Hormone Preparations



Form RS1302 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 118

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Oxandrolone - Tab 2.5 mg	
INITIATION Prerequisites (tick box where appropriate)	
O For the treatment of burns patients	

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	CRIBE	ER PATIENT:
Name):	
Ward	:	NHI:
Cina	calce	et et
Re-a	ssessnequisit Pr	I – parathyroid carcinoma or calciphylaxis ment required after 6 months tes (tick boxes where appropriate) rescribed by, or recommended by a nephrologist or endocrinologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. The patient has been diagnosed with a parathyroid carcinoma (see Note) The patient has persistent hypercalcaemia (serum calcium greater than or equal to 3 mmol/L) despite previous first-line treatments including sodium thiosulfate (where appropriate) and bisphosphonates
		The patient is symptomatic
	or	The patient has been diagnosed with calciphylaxis (calcific uraemic arteriolopathy) The patient has symptomatic (e.g. painful skin ulcers) hypercalcaemia (serum calcium greater than or equal to 3 mmol/L) The patient's condition has not responded to previous first-line treatments including bisphosphonates and sodium thiosulfate
Prer (equisit Pr	ATION – parathyroid carcinoma or calciphylaxis tes (tick boxes where appropriate) rescribed by, or recommended by a nephrologist or endocrinologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
and	and	The patient's serum calcium level has fallen to < 3mmol/L The patient has experienced clinically significant symptom improvement
Note	: This	does not include parathyroid adenomas unless these have become malignant.
		I – primary hyperparathyroidism tes (tick boxes where appropriate)
	and and and	Patient has primary hyperparathyroidism O Patient has hypercalcaemia of more than 3 mmol/L with or without symptoms O Patient has hypercalcaemia of more than 2.85 mmol/L with symptoms O Surgery is not feasible or has failed O Patient has other comorbidities, severe bone pain, or calciphylaxis

I confirm that the above details are correct:

Signed: Date:

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	e:				Name:	
Ward	:				NHI:	
Cina	calc	et -	conti	nued		
Re-a	ssess	smen	t requ	dary or tertiary hyperparathyroidism ired after 6 months ooxes where appropriate)		
		or	O O	Patient has tertiary hyperparathyroidism and markedly elevated parathyroid hormone (PTH) with hypercalcaemia Patient has symptomatic secondary hyperparathyroidism and elevated PTH		
	and	\circ	Patie	nt is on renal replacement therapy		
		or	O O O	Residual parathyroid tissue has not been localised despit Parathyroid tissue is surgically inaccessible Parathyroid surgery is not feasible	ite repeat unsuccessful parathyroid explorations	
Re-a	ssess	smen	t requ	secondary or tertiary hyperparathyroidism iried after 12 months boxes where appropriate)		
	The patient has had a kidney transplant, and following a treatment free interval of at least 12 weeks a clinically at hormone (PTH) level to support ongoing cessation of treatment has not been reached The patient has not received a kidney transplant and trial of withdrawal of cinacalcet is clinically inappropriate				nt has not been reached	

I confirm that the above details are correct:

0:	D - 1 - 1	
Zigneg.	i jate:	
Oigilica.	 Duic.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Cabergoline	
INITIATION Prerequisites (tick boxes where appropriate) O Inhibition of lactation	
or Patient has hyperprolactinemia or	
Note: Indication marked with * is an unapproved indication.	

I confirm that the above details are correct:

0:	D - 1 - 1	
Zigneg.	i jate:	
Oigilica.	 Duic.	

RS1826 - Somatropin

l	Prader-Willi syndrome - INITIATION	.126	
l	Prader-Willi syndrome - CONTINUATION		
l	Turner syndrome - INITIATION	.123	
l	Turner syndrome - CONTINUATION	.124	
l	Adults and adolescents - INITIATION	.127	
l	Adults and adolescents - CONTINUATION	.128	
l	Growth hormone deficiency in children - INITIATION	.123	
l	Growth hormone deficiency in children - CONTINUATION	.123	
l	Short stature due to chronic renal insufficiency - INITIATION	.125	
l	Short stature due to chronic renal insufficiency - CONTINUATION	.125	
l	Short stature without growth hormone deficiency - INITIATION		
l	Short stature without growth hormone deficiency - CONTINUATION	.124	
ı			

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

CRIE	BER			ı	PATIENT:
ame:					Name:
Ward: NHI:					NHI:
atro	pin				
INITIATION – growth hormone deficiency in children Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and Growth hormone deficiency causing symptomatic hypoglycaemia, or with other significant growth hormone deficient sequelae (e.g. cardiomyopathy, hepatic dysfunction) and diagnosed with GH < 5 mcg/l on at least two random blood samples in the first 2 weeks of life, or from samples during established hypoglycaemia (whole blood glucose < 2 mmol/l using a laboratory device) Height velocity < 25th percentile for age; and adjusted for bone age/pubertal status if appropriate over 6 or 12 months using the standards of Tanner and Davies (1985) and A current bone age is < 14 years (female patients) or < 16 years (male patients) Peak growth hormone value of < 5.0 mcg per litre in response to two different growth hormone stimulation tests. In children who are 5 years or older, GH testing with sex steroid priming is required If the patient has been treated for a malignancy, they should be disease free for at least one year based upon follow-up laboratory and radiological imaging appropriate for the malignancy, unless there are strong medical reasons why this is either					
ssess e quis	sment sites (Presci	requitick b	growth hormone deficiency in children uired after 12 months boxes where appropriate) by, or recommended by an endocrinologist or		docrinologist, or in accordance with a protocol or guideline that has been
and and and	0 0 0	Heigh horm Heigh No se	the velocity is greater than or equal to 25th percentage treatment, as calculated over six months until the velocity is greater than or equal to 2.0 cm percentage adverse effect that the patients specialise	entile for age using the star er year, as ca st considers i	e (adjusted for bone age/pubertal status if appropriate) while on growth indards of Tanner and Davis (1985)
ssess equis	Presciendors	requitick britished sed britished.	uired after 12 months boxes where appropriate) d by, or recommended by an endocrinologist or by the Health NZ Hospital. patient has a post-natal genotype confirming To the state of the s	urner Syndro	
	and	atropin ATION - g ssessment equisites (and	atropin ATION – grown seessment requisites (tick of and	ATION – growth hormone deficiency in children seessment required after 12 months equisites (tick boxes where appropriate) Prescribed by, or recommended by an endocrinologist or endorsed by the Health NZ Hospital. Growth hormone deficiency causing symptomatic horadiomyopathy, hepatic dysfunction) and diagnose life, or from samples during established hypoglycae or Height velocity < 25th percentile for age; and standards of Tanner and Davies (1985) A current bone age is < 14 years (female patinal and Peak growth hormone value of < 5.0 mcg per who are 5 years or older, GH testing with sex and Island Islan	ATION – growth hormone deficiency in children issessment required after 12 months inquisites (tick boxes where appropriate) Prescribed by, or recommended by an endocrinologist or paediatric energrates or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during established hypoglycaemia (whole be ille, or from samples during e

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRES	CRIBER	PATIENT:
Name	:	
Ward:		NHI:
Som	atropin	- continued
CON Re-a	TINUATION Seessmer equisites Preso	ON – Turner syndrome at required after 12 months (tick boxes where appropriate) cribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been resed by the Health NZ Hospital. Height velocity greater than or equal to 50th percentile for age (while on growth hormone calculated over 6 to 12 months using the Ranke's Turner Syndrome growth velocity charts) Height velocity is greater than or equal to 2 cm per year, calculated over six months A current bone age is 14 years or under
	and on the state of the state o	No serious adverse effect that the specialist considers is likely to be attributable to growth hormone treatment has occurred No malignancy has developed since starting growth hormone
Re-a	ssessmer equisites Prese	short stature without growth hormone deficiency at required after 12 months (tick boxes where appropriate) cribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been rised by the Health NZ Hospital. The patient's height is more than 3 standard deviations below the mean for age or for bone age if there is marked growth acceleration
	and and and	or delay Height velocity is < 25th percentile for age (adjusted for bone age/pubertal status if appropriate), as calculated over 6 to 12 months using the standards of Tanner and Davies(1985) A current bone age is < 14 years (female patients) or < 16 years (male patients) The patient does not have severe chronic disease (including malignancy or recognized severe skeletal dysplasia) and is not receiving medications known to impair height velocity
Re-a	ssessmer equisites Prese	ON – short stature without growth hormone deficiency at required after 12 months (tick boxes where appropriate) cribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been rised by the Health NZ Hospital.
	and on and on and on one of the o	Height velocity is greater than or equal to 50th percentile (adjusted for bone age/pubertal status if appropriate) as calculated over 6 to 12 months using the standards of Tanner and Davies (1985) Height velocity is greater than or equal to 2 cm per year as calculated over six months Current bone age is 14 years or under (female patients) or 16 years or under (male patients) No serious adverse effect that the patient's specialist considers is likely to be attributable to growth hormone treatment has occurred

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	CRIBER	BER PATIENT:	
Name	:	Name:	
Ward:		NHI:	
Som	atropin	pin - continued	
INITI	ATION –	N – short stature due to chronic renal insufficiency	
		ment required after 12 months ites (tick boxes where appropriate)	
() Pres	Prescribed by, or recommended by an endocrinologist, paediatric endocrinologist or renal physic paediatric endocrinologist, or in accordance with a protocol or guideline that has been endo	
and	and	The patient's height is more than 2 standard deviations below the mean	
	and	Height velocity is < 25th percentile (adjusted for bone age/pubertal status if appropriate) standards of Tanner and Davies (1985)	as calculated over 6 to 12 months using the
	and	A current bone age is to 14 years or under (female patients) or to 16 years or under (ma	
	and	 The patient is metabolically stable, has no evidence of metabolic bone disease and abse The patient is under the supervision of a specialist with expertise in renal medicine 	ence of any other severe chronic disease
	and	The patient is under the supervision of a specialist with expense in terial medicine	
	or	The patient has a GFR less than or equal to 30 ml/min/1.73 m² as measured by to creatinine (umol/l × 40 = corrected GFR (ml/min/1.73 m²) in a child who may or more	he Schwartz method (Height(cm)/plasma ay not be receiving dialysis
		O The patient has received a renal transplant and has received < 5mg/ m² /day of pr	ednisone or equivalent for at least 6 months
_			
Re-a	ssessmer	ATION – short stature due to chronic renal insufficiency ment required after 12 months	
Prer	equisites	ites (tick boxes where appropriate)	
and		Prescribed by, or recommended by an endocrinologist, paediatric endocrinologist or renal physic paediatric endocrinologist, or in accordance with a protocol or guideline that has been endo	
	0	Height velocity is greater than or equal to 50th percentile (adjusted for bone age/puberta 12 months using the standards of Tanner and Davies (1985)	Il status if appropriate) as calculated over 6 to
	and	O Height velocity is greater than or equal to 2 cm per year as calculated over six months	
	and	A current bone age is 14 years or under (female patients) or 16 years or under (male pa	atients)
	\circ	igcap No serious adverse effect that the patients specialist considers is likely to be attributable	to growth hormone has occurred
	and	O No malignancy has developed after growth hormone therapy was commenced	
	and	O The patient has not experienced significant biochemical or metabolic deterioration confir	med by diagnostic results
	\circ	O The patient has not received renal transplantation since starting growth hormone treatm	ent
	and	If the patient requires transplantation, growth hormone prescription should cease before be made after transplantation based on the above criteria	transplantation and a new application should

I confirm that the above details are correct:

Signed: Date:

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: Name:		
Ward:	NHI:	
Somatropin	- continued	
INITIATION – I Re-assessmen Prerequisites	Prader-Willi syndrome It required after 12 months (tick boxes where appropriate) cribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been resed by the Health NZ Hospital. The patient has a diagnosis of Prader-Willi syndrome that has been confirmed by genetic testing or clinical scoring criteria The patient is aged six months or older A current bone age is < 14 years (female patients) or < 16 years (male patients) Sleep studies or overnight oximetry have been performed and there is no obstructive sleep disorder requiring treatment, or if an obstructive sleep disorder is found, it has been adequately treated under the care of a paediatric respiratory physician and/or ENT surgeon	
or	The patient is aged two years or older There is no evidence of type II diabetes or uncontrolled obesity defined by BMI that has increased by greater than or equal to 0.5 standard deviations in the preceding 12 months The patient is aged between six months and two years and a thorough upper airway assessment is planned to be undertaken prior to treatment commencement and at six to 12 weeks following treatment initiation	
Prerequisites Presequing endo	ON – Prader-Willi syndrome It required after 12 months (tick boxes where appropriate) cribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been resed by the Health NZ Hospital.	
and	Height velocity is greater than or equal to 50th percentile (adjusted for bone age/pubertal status if appropriate) as calculated over 6 to 12 months using the standards of Tanner and Davies (1985) Height velocity is greater than or equal to 2 cm per year as calculated over six months A current bone age is 14 years or under (female patients) or 16 years or under (male patients) No serious adverse effect that the patient's specialist con siders is likely to be attributable to growth hormone treatment has occurred No malignancy has developed after growth hormone therapy was commenced The patient has not developed type II diabetes or uncontrolled obesity as defined by BMI that has increased by greater than or equal to 0.5 standard deviations in the preceding 12 months	

I confirm that the above details are correct:

Signed: Date:

Use this checklist to determine if a patient meets the restrictions for funding Schedule. For community funding, see the Special Authority Criteria.	ng in the hospital setting . For more details, refer to Section H of the Pharmaceutical
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Somatropin - continued	
INITIATION – adults and adolescents Re-assessment required after 12 months	
Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by an endocrinologist or paec endorsed by the Health NZ Hospital.	diatric endocrinologist, or in accordance with a protocol or guideline that has been
	use growth hormone deficiency (e.g. surgical removal of the pituitary for
The patient has undergone appropriate treatment of other	er hormonal deficiencies and psychological illnesses
The patient has severe growth hormone deficiency (see	e notes)
O The patient's serum IGF-I is more than 1 standard devia	ation below the mean for age and sex
The patient has poor quality of life, as defined by a score growth hormone deficiency (QoL-AGHDA®)	re of 16 or more using the disease-specific quality of life questionnaire for adult
equal to 3 mcg per litre during an adequately performed insulin toleranc Patients with one or more additional anterior pituitary hormone deficiency isolated growth hormone deficiency require two growth hormone stimula an additional test is required, an arginine provocation test can be used voten dose of somatropin should be started at 0.2 mg daily and be titrated for age and sex; and The dose of somatropin not to exceed 0.7 mg per day for male patients,	cies and a known structural pituitary lesion only require one test. Patients with ation tests, of which, one should be ITT unless otherwise contraindicated. Where with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre. d by 0.1 mg monthly until it is within 1 standard deviation of the mean normal value

I confirm that the above details are correct: Signed: Date:

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Somatropin - continued	
CONTINUATION – adults and Re-assessment required after Prerequisites (tick boxes when the analysis of the pating and the patin	d adolescents 12 months ere appropriate) commended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been alth NZ Hospital. Ident has been treated with somatropin for < 12 months as been an improvement in the Quality of Life Assessment defined as a reduction of at least 8 points on the Quality of essment of Growth Hormone Deficiency in Adults (QoL-AGHDA®) score from baseline GF-I levels have increased to within ±1SD of the mean of the normal range for age and sex se of somatropin does not exceed 0.7 mg per day for male patients, or 1 mg per day for female patients ent has been treated with somatropin for more than 12 months tent has not had a deterioration in Quality of Life defined as a 8 point or greater increase from their lowest QoL-AGHDA®) threatment (other than due to obvious external factors such as external stressors) GF-I levels have continued to be maintained within ±1SD of the mean of the normal range for age and sex (other than bus external factors) are of somatropin has not exceeded 0.7 mg per day for male patients or 1 mg per day for female patients ent has had a Special Authority approval for somatropin for childhood deficiency in children and no longer meets the criteria under this indication tent has severe growth hormone deficiency (see notes) tent has severe growth hormone deficiency (see notes) tent has poor quality of life, as defined by a score of 16 or more using the disease-specific quality of life questionnaire growth hormone deficiency (QoL-AGHDA®) alts and adolescents, severe growth hormone deficiencies and a known structural pituitary lesion only require one test. Patients with hornor pituitary hormone deficiencies and a known structural pituitary lesion only require one test. Patients with hornor pituitary hormone deficiencies and a known structural pituitary lesion only require one test. Patients with hornor pituitary hormone deficiencies and a known structural pituitary lesion only require one test. Patients with

Page 129

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:	Name:			
Ward:	NHI:			
Liothyronine sodium - Tab 20 mcg				
INITIATION				
Prerequisites (tick box where appropriate)				
O For a maximum of 14 days' treatment in patients with thyroid cancer who are due to receive radioiodine therapy				

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER			PATIENT:	
Name:			Name:	
Ward:			NHI:	
Prop	ylthiou	racil		
INITIATION Prerequisites (tick boxes where appropriate)		(tick boxes where appropriate)		
	The patient has hyperthyroidism			
		The patient is intolerant of carbimazole or carbimazole is conti	raindicated	

Infections



Page 132

PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Streptomycin sulphate				
INITIATION				
Prerequisites (tick box where appropriate)				
Prescribed by, or recommended by a clinical microbiologist, infection protocol or guideline that has been endorsed by the Health NZ Hosp				

Form RS1041 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:	Name:			
Ward:	NHI:			
Amikacin				
INITIATION				
Prerequisites (tick box where appropriate)				
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				

Form RS1044 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:	Name:			
Ward:	NHI:			
Tobramycin				
INITIATION				
Prerequisites (tick box where appropriate)				
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Tobramycin Solution for inhalation 60 mg per ml, 5 ml	
Prerequisites (tick box where appropriate)	
O Patient has cystic fibrosis	

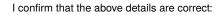
Signed: Date:

Form RS1475 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 136

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Tobramcyin	
INITIATION Prerequisites (tick box where appropriate)	
O For addition to orthopaedic bone cement	



C:	D-1	
Signed.	Date:	
Oigilica.	 Daic.	

Form RS1603 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 137

PRESCRIBER	PATIENT:			
Name:	. Name:			
Ward:	NHI:			
Paromomycin				
INITIATION Prerequisites (tick box where appropriate)				
O Prescribed by, or recommended by a clinical microbiologist, infect or guideline that has been endorsed by the Health NZ Hospital.	ious disease specialist or gastroenterologist, or in accordance with a protocol			

Form RS1046 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 138

PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Imipenem with cilastatin				
INITIATION				
Prerequisites (tick box where appropriate)				
O Prescribed by, or recommended by a clinical microbiologist or infect been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has			

Form RS1045 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 139

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:	Name:
Ward:	NHI:
Ertapenem	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infect been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

Form RS1047 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 140

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Meropenem	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infect been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

Page 141

PRES	CRIB	ER			PATIENT:
Name	:				Name:
Ward:					NHI:
Cefta	zidi	me	with	avibactam	
INITIA Prere			(tick b	oxes where appropriate)	
	Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital O Proven infection with a carbapenem-resistant micro-organism, based on microbiology report				
		OI .	0	Probable infection with a carbapenem-resistant micro-o disease specialist.	rganism, based on assessment by a clinical microbiologist or infectious

Form RS1048 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 142

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Ceftazadime		
INITIATION Prerequisites (tick box where appropriate)		
Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		

Form RS1049 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 143

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:	Name:			
Ward:	NHI:			
Cefepime				
INITIATION				
Prerequisites (tick box where appropriate)				
O Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that been endorsed by the Health NZ Hospital.				

PRESCRIBER		IBER	PATIENT:	
Name	e:		Name:	
Ward:	:		NHI:	
Ceftaroline				
INITIATION – multi-resistant organisn salvage therapy Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and				
	or	O For patients where alternative therapies have failed		
	J.	O For patients who have a contraindication or hypersensitivity to	standard current therapies	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Roxithromycin tab dispersible 50 mg	
INITIATION Prerequisites (tick box where appropriate)	
Only for use in patients under 12 years of age	

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

May 2025

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Clarithromycin	
INITIATION – Tab 250 mg and oral liquid Prerequisites (tick boxes where appropriate)	
Atypical mycobacterial infection O Mycobacterium tuberculosis infection where there is drug resi or O Helicobacter pylori eradication or O Prophylaxis of infective endocarditis associated with surgical or	
INITIATION – Tab 500 mg Prerequisites (tick box where appropriate) O Helicobacter pylori eradication	
INITIATION – Infusion Prerequisites (tick boxes where appropriate) O Atypical mycobacterial infection or O Mycobacterium tuberculosis infection where there is drug resi or O Community-acquired pneumonia	stance or intolerance to standard pharmaceutical agents
Community adequated priorition	

C:	D-1	
Signed.	Date:	
Oigilica.	 Daic.	

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

May 2025

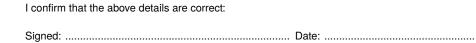
PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:NHI:			
Azithromycin			
INITIATION – bronchiolitis obliterans syndrome, cystic fibrosis and atypic Prerequisites (tick boxes where appropriate)	ical Mycobacterium infections		
or O Patient has received a lung transplant and requires prophylaxi	bone marrow transplant and requires treatment for bronchiolitis is for bronchiolitis obliterans syndrome* domonas aeruginosa or Pseudomonas related gram negative organisms*		
INITIATION – non-cystic fibrosis bronchiectasis* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a respiratory specialist or paedia endorsed by the Health NZ Hospital. To prophylaxis of exacerbations of non-cystic fibrosis bronchi and Patient is aged 18 and under Patient has had 3 or more exacerbations of their bronch	iectasis*		
Patient has had 3 acute admissions to hospital for treatr Note: Indications marked with * are unapproved indications. A maximum of 2 in the community.	ment of infective respiratory exacerbations within a 12 month period 44 months of azithromycin treatment for non-cystic fibrosis will be subsidised		
CONTINUATION – non-cystic fibrosis bronchiectasis* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a respiratory specialist or paedia endorsed by the Health NZ Hospital. The patient has completed 12 months of azithromycin treatme and Following initial 12 months of treatment, the patient has not responshiectasis for a further 12 months, unless considered clinication The patient will not receive more than a total of 24 months' azith the community. INITIATION – other indications Re-assessment required after 5 days Prerequisites (tick box where appropriate) For any other condition	ent for non-cystic fibrosis bronchiectasis eceived any further azithromycin treatment for non-cystic fibrosis ically inappropriate to stop treatment ithromycin cumulative treatment (see note)		

Form RS1598 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Azithromycin - continued	
CONTINUATION – other indications Re-assessment required after 5 days Prerequisites (tick box where appropriate)	
O For any other condition	



Form RS1054 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 149

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:	Name:	
Ward:	NHI:	
Ticarcillin with clavulanic acid		
INITIATION		
Prerequisites (tick box where appropriate)		
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		

I confirm that the above details are correct:

C:	D-1	
Signed.	Date:	
Oigilica.	 Daic.	

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 150

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Piperacillin with tazobactam		
INITIATION		
Prerequisites (tick box where appropriate)		
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		

Form RS1055 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 151

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Ciprofloxacin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infection been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

May 2025

PRES	CRIB	BER			PATIENT:
Name	:				
Ward:					NHI:
Moxi	flox	acir	1		
	equis	ites	(tick bo	oxes v	recommended by an infectious disease specialist, clinical microbiologist or respiratory specialist, or in accordance with a
and		oroto	col or g	juide	line that has been endorsed by the Health NZ Hospital.
		an		Activ	e tuberculosis
			or	0	Documented resistance to one or more first-line medications
			or	0	Suspected resistance to one or more first-line medications (tuberculosis assumed to be contracted in an area with known resistance), as part of regimen containing other second-line agents
			or	0	Impaired visual acuity (considered to preclude ethambutol use)
			or	0	Significant pre-existing liver disease or hepatotoxicity from tuberculosis medications
				<u>O</u>	Significant documented intolerance and/or side effects following a reasonable trial of first-line medications
	or or	O O	-		rium avium-intracellulare complex not responding to other therapy or where such therapy is contraindicated nder five years of age and has had close contact with a confirmed multi-drug resistant tuberculosis case
			Pneum		where appropriate)
and	Э г	Preso	cribed b	oy, or	recommended by an infectious disease specialist or clinical microbiologist, or in accordance with a protocol or guideline that ed by the Health NZ Hospital.
	(0	Immu	nocor	mpromised patient with pneumonia that is unresponsive to first-line treatment
	or (0	Pneur	noco	ccal pneumonia or other invasive pneumococcal disease highly resistant to other antibiotics
INITI	ATIOI	N – F	Penetra	ating	eye injury
Prere	equis	ites	(tick bo	ox wh	ere appropriate)
and		Preso Hosp		ງy, or	recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
() F	Five (days tre	eatme	ent for patients requiring prophylaxis following a penetrating eye injury
1					a genitalium where appropriate)
	and	0	Has n	ucleid	c acid amplification test (NAAT) confirmed Mycoplasma genitalium and is symptomatic
			\circ	Has t	tried and failed to clear infection using azithromycin
		or	0	Has I	laboratory confirmed azithromycin resistance
	and (0	Treatr	nent i	is only for 7 days

Form RS1059 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 153

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Tigecycline	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

Form RS1063 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 154

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Daptomycin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

Form RS1065 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 155

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Lincomycin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infection been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

Form RS1066 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 156

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Linezolid	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

Form RS1067 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 157

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Sulphadiazine	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or maternal-foetal medicine specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

Form RS1068 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 158

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Teicoplanin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infection been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

Form RS1315 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 159

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Fosfomycin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

Form RS1322 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 160

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pivmecillinam	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infection been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

Form RS1069 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 161

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Vancomycin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infection been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Aztreonam, Chloramphenicol	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infect been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

Form RS1061 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 163

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Clindamycin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

Form RS1064 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 164

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Fusidic acid	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

Form RS1062 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 165

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Colistin sulphomethate [Colestimethate]	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

Form RS1410 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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.

PRESCR	IBER	PATIENT:
Name:		Name:
Ward:		NHI:
Ketoco	nazole - Tab 200 mg	
INITIATION Prerequisites (tick box where appropriate)		
O Prescribed by, or recommended by an oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:
Name:	lame:
Ward:	IHI:
Amphotericin B - Inj (liposomal) 50 mg vial	
Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a clinical microbiologist, haematologist, transplant specialist, or in accordance with a protocol or guideline that and Proven or probable invasive fungal infection, to be prescribed until or Possible invasive fungal infection and	has been endorsed by the Health NZ Hospital.

Form RS1316 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Amphotericin B - Inj 50 mg vial				
INITIATION Prerequisites (tick box where appropriate)				
O Prescribed by, or recommended by a clinical microbiologist, haematologist, infectious disease specialist, oncologist, respiratory specialist or transplant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				

Form RS1072 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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PRESCR	IBER	PATIENT:			
Name:		Name:			
Ward:		NHI:			
Fluconazole					
INITIATI	ON				
Prerequ	isites (tick box where appropriate)				
0	Prescribed by, or recommended by a consultant, or in accordance v Hospital.	with a protocol or guideline that has been endorsed by the Health NZ			

Form RS1073 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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PRESCRIBER	PATIENT:				
Name:	Name:				
Ward:	NHI:				
Itraconazole					
INITIATION					
Prerequisites (tick box where appropriate)					
O Prescribed by, or recommended by a clinical immunologist, clinical rewith a protocol or guideline that has been endorsed by the Health N.	nicrobiologist, dermatologist or infectious disease specialist, or in accordance Z Hospital.				

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.

Name:				
Vard:NHI:				
Voriconazole				
INITIATION – Proven or probable aspergillus infection Prerequisites (tick boxes where appropriate)				
Prescribed by, or recommended by a clinical microbiologist, haematologist or infectious disease specialist, or in accordanguideline that has been endorsed by the Health NZ Hospital. and	nce with a protocol or			
Patient is immunocompromised O Patient has proven or probable invasive aspergillus infection				
INITIATION – Possible aspergillus infection Prerequisites (tick boxes where appropriate)				
Prescribed by, or recommended by a clinical microbiologist, haematologist or infectious disease specialist, or in accordan guideline that has been endorsed by the Health NZ Hospital. and	nce with a protocol or			
O Patient is immunocompromised				
Patient has possible invasive aspergillus infection				
A multidisciplinary team (including an infectious disease physician) considers the treatment to be appropriate				
INITIATION – Resistant candidiasis infections and other moulds Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a clinical microbiologist, haematologist or infectious disease specialist, or in accordant	nce with a protocol or			
guideline that has been endorsed by the Health NZ Hospital.				
O Patient is immunocompromised and				
O Patient has fluconazole resistant candidiasis				
O Patient has mould strain such as Fusarium spp. and Scedosporium spp				
A multidisciplinary team (including an infectious disease physician or clinical microbiologist) considers the treatment	nt to be appropriate			
INITIATION – Invasive fungal infection prophylaxis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been expected to the protocol or guideline that has been expected by the proto	endorsed by the Health			
NZ Hospital.				
The patient is at risk of invasive fungal infection and				
O Voriconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease spaediatric haematologist or paediatric oncologist	specialist,			
Prescribing voriconazole is in accordance with a protocol or guideline that has been endorsed by the Health I Whatu Ora Hospital in the specific settings where there is a greater than 10% risk of invasive fungal infection				

I confirm that the above details are correct:

Cianad.	Data.	
Signed	Dale	

PRES	CRIB	BER			PATIENT:
Name	e:				Name:
Ward	:				NHI:
Vori	cona	zole	- co	ontinued	
Re-a	ssess equis F	ites (t requ (tick b		cordance with a protocol or guideline that has been endorsed by the Health
	and	0	The	patient is at risk of invasive fungal infection	
		or	0	Voriconazole is prescribed by, or recommended by a had paediatric haematologist or paediatric oncologist	ematologist, transplant physician, infectious disease specialist,
		OI .	0		I or guideline that has been endorsed by the Health New Zealand - Te s a greater than 10% risk of invasive fungal infection (IFI)
l	$\overline{}$				

I confirm that the above details are correct:		
Signed:	Data:	

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.

PRES	CRIE	BER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Posa	acon	azo	le	
Re-a	equis F	sment sites (tick b	by, or recommended by a haematologist or infectious disease specialist, or in accordance with a protocol or guideline that has been by the Health NZ Hospital. Patient has acute myeloid leukaemia Patient is planned to receive a stem cell transplant and is at high risk for aspergillus infection
	and	0	Patie	ent is to be treated with high dose remission induction therapy or re-induction therapy
Re-a	eiupe I	sment sites (Presc endor	t requ (tick b ribed sed b	by, or recommended by a haematologist or infectious disease specialist, or in accordance with a protocol or guideline that has been by the Health NZ Hospital. ent has previously received posaconazole prophylaxis during remission induction therapy Patient is to be treated with high dose remission re-induction therapy Patient is to be treated with high dose consolidation therapy Patient is receiving a high risk stem cell transplant
Re-a	ssess eiupe	sment sites (Presc NZ Ho	t requ (tick b ribed ospita	live fungal infection prophylaxis spired after 6 months boxes where appropriate) by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health al. patient is at risk of invasive fungal infection Posaconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease specialist, paediatric haematologist or paediatric oncologist Prescribing posaconazole is in accordance with a protocol or guideline that has been endorsed by the Health New Zealand - Te Whatu Ora Hospital in the specific settings where there is a greater than 10% risk of invasive fungal infection (IFI)

I confirm that the above details are correct:

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PATIENT:
Name:
NHI:
ccordance with a protocol or guideline that has been endorsed by the Health
naematologist, transplant physician, infectious disease specialist,
col or guideline that has been endorsed by the Health New Zealand - Te is a greater than 10% risk of invasive fungal infection (IFI)

Form RS1279 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:	Name:				
Ward:	NHI:				
Flucytosine					
INITIATION					
Prerequisites (tick box where appropriate)					
O Prescribed by, or recommended by a clinical microbiologist or infect been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has				

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER					PATIENT:
Name:					Name:
Ward:					NHI:
Casp	ofu	ngin			
	INITIATION Prerequisites (tick boxes where appropriate) Or Prescribed by, or recommended by a clinical microbiologist, haematologist, infectious disease specialist, oncologist, respiratory specialist or transplant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
	or	O Pr	0	en or probable invasive fungal infection, to be prescribed under the properties of the prescribed under the probable invasive fungal infection	under an established protocol
			O 	A multidisciplinary team (including an infectious disease appropriate	physician or a clinical microbiologist) considers the treatment to be

Form RS1077 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 177

PRESCRIBER	PATIENT:				
Name:	Name:				
Ward:	NHI:				
Clofazimine					
INITIATION					
Prerequisites (tick box where appropriate)					
O Prescribed by, or recommended by a clinical microbiologist, dermatologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.					

Form RS1078 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 178

PRESCR	IBER	PATIENT:			
Name:		Name:			
Ward:		NHI:			
Dapson	e				
INITIATION Prerequisites (tick box where appropriate)					
0	Prescribed by, or recommended by a clinical microbiologist, dermatologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				

Form RS1079 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 179

PRESCRIE	BER	PATIENT:			
Name:		Name:			
Ward:		NHI:			
Cyclose	rine				
INITIATION Prerequisites (tick box where appropriate)					
	Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 180

PRESCRIBER	PATIENT:					
Name:	Name:					
Ward:	NHI:					
Isoniazid with rifampicin						
INITIATION						
Prerequisites (tick box where appropriate)						
O Prescribed by, or recommended by a clinical microbiologist, dermatologist, paediatrician, public health physician or internal medicine physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.						

Page 181

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pyrazinamide	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Rifampicin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, dermatologist, internal medicine physician, paediatrician or public health physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

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	CRIBER		PATIENT:
Name):		Name:
Ward:			NHI:
	aquiline	multi-drug resistant tuberculosis	
Re-a	ssessmer	nt required after 6 months (tick boxes where appropriate)	
	and	The person has multi-drug resistant tuberculosis (MDR-TB)	
		Ministry of Health's Tuberculosis Clinical Network has reviewed treatment regimen	d the individual case and recommends bedaquiline as part of the

Form RS1281 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 184

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Isoniazid		
INITIATION		
Prerequisites (tick box where appropriate)		
Prescribed by, or recommended by a clinical microbiologist, dermatologist, paediatrician, public health physician or internal medicine physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		

Form RS1086 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 185

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Rifabutin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, gastroe accordance with a protocol or guideline that has been endorsed by	nterologist, infectious disease specialist or respiratory specialist, or in the Health NZ Hospital.

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Oigilica.	 Duic.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Ethambutol hydrochloride	
INITIATION Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Para-aminosalicylic Acid	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

Form RS1084 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Protionamide	
INITIATION Proportion (diels becomb on a proportion)	
Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a clinical microbiologist, infection protocol or guideline that has been endorsed by the Health NZ Hosp	us disease specialist or respiratory specialist, or in accordance with a bital.

Form RS1088 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 189

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Albendazole	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

Form RS1283 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 190

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Ivermectin		
INITIATION Prerequisites (tick box where appropriate)		
O Prescribed by, or recommended by a clinical microbiologist, dermatologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Artemether with lumefantrine	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

Form RS1091 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 192

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:	Name:
Ward:	NHI:
Artesunate	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infect been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

Form RS1092 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 193

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:	Name:
Ward:	NHI:
Atovaquone with proguanil hydrochloride	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infect been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

Form RS1093 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 194

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:	Name:
Ward:	NHI:
Chloroquine phosphate	
INITIATION Prerequisites (tick box where appropriate)	
Prescribed by, or recommended by a clinical microbiologist, dermate a protocol or guideline that has been endorsed by the Health NZ Ho	ologist, infectious disease specialist or rheumatologist, or in accordance with ospital.

Form RS1094 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Mefloquine hydrochloride	
INITIATION Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, dermatologist, infectious disease specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

Form RS1096 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pentamidine isethionate	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infection been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

Form RS1097 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 197

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:	Name:
Ward:	NHI:
Primaquine phosphate	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infection been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

Form RS1098 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 198

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pyrimethamine	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or maternal-foetal medicine specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

Form RS1099 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 199

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Quinine dihydrochloride	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Sodium stibogluconate	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infect been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Spiramycin	
INITIATION Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a maternal-foetal medicine specific by the Health NZ Hospital.	cialist, or in accordance with a protocol or guideline that has been endorsed

Form RS1095 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:	Name:
Ward:	NHI:
Nitazoxanide	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

May 2025

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:		Name:
Ward:		NHI:
lon-Nucleoside	e Reverse Transcriptase Inhibitors	
INITIATION – Confi Prerequisites (tick	irmed HIV box where appropriate)	
O Patient ha	as confirmed HIV infection	
	ention of maternal transmission boxes where appropriate)	
or	vention of maternal foetal transmission atment of the newborn for up to eight weeks	
Prerequisites (tick	exposure prophylaxis following exposure to HIV boxes where appropriate) atment course to be initiated within 72 hours post exposure	e
or O	Patient has had condomless anal intercourse or reception unknown or detectable viral load greater than 200 copies and the patient has shared intravenous injecting equipment with	
or O		nician considers that the risk assessment indicates prophylaxis is
	Patient has had condomless anal intercourse with a per is unknown	son from a high HIV prevalence country or risk group whose HIV status
Note: Refer to local	health pathways or the Australasian Society for HIV, Viral	Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.a
Prerequisites (tick	utaneous exposure box where appropriate) as percutaneous exposure to blood known to be HIV positive	ve

I confirm that the above details are correct:

May 2025

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:	Name:
Ward:	NHI:
Nucleoside Reverse Transcriptase Inhibitors	
INITIATION – Confirmed HIV Prerequisites (tick box where appropriate)	
O Patient has confirmed HIV infection	
INITIATION – Prevention of maternal transmission Prerequisites (tick boxes where appropriate)	
O Prevention of maternal foetal transmission O Treatment of the newborn for up to eight weeks	
INITIATION – Post-exposure prophylaxis following exposure to HIV Prerequisites (tick boxes where appropriate) Treatment course to be initiated within 72 hours post exposure to the initiated within 72 hours post exposure to HIV	osure
or Patient has had condomless anal intercourse or recunknown or detectable viral load greater than 200 condomness. Patient has shared intravenous injecting equipment.	
or	e clinician considers that the risk assessment indicates prophylaxis is
	person from a high HIV prevalence country or risk group whose HIV status
Note: Refer to local health pathways or the Australasian Society for HIV,	/iral Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.as
INITIATION – Percutaneous exposure Prerequisites (tick box where appropriate)	

I confirm that the above details are correct:

May 2025

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:	Name:
Ward:	NHI:
Protease Inhibitors	
INITIATION – Confirmed HIV Prerequisites (tick box where appropriate)	
O Patient has confirmed HIV infection	
INITIATION – Prevention of maternal transmission Prerequisites (tick boxes where appropriate)	
O Prevention of maternal foetal transmission or O Treatment of the newborn for up to eight weeks	
INITIATION – Post-exposure prophylaxis following exposure to HIV Prerequisites (tick boxes where appropriate) Treatment course to be initiated within 72 hours post exposure and	e
Patient has had condomless anal intercourse or reception unknown or detectable viral load greater than 200 copies or Patient has shared intravenous injecting equipment with or Patient has had non-consensual intercourse and the clin required or	
Note: Refer to local health pathways or the Australasian Society for HIV, Viral	Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.ashr
INITIATION – Percutaneous exposure Prerequisites (tick box where appropriate)	
O Patient has percutaneous exposure to blood known to be HIV positive	ve

I confirm that the above details are correct:

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:	Name:
Ward:	NHI:
Strand Transfer Inhibitors	
INITIATION – Confirmed HIV Prerequisites (tick box where appropriate) O Patient has confirmed HIV infection	
INITIATION – Prevention of maternal transmission Prerequisites (tick boxes where appropriate)	
O Prevention of maternal foetal transmission or O Treatment of the newborn for up to eight weeks	
INITIATION – Post-exposure prophylaxis following exposure to HIV Prerequisites (tick boxes where appropriate) Treatment course to be initiated within 72 hours post exposure and	e
Patient has had condomless anal intercourse or reception unknown or detectable viral load greater than 200 copies or Patient has shared intravenous injecting equipment with or Patient has had non-consensual intercourse and the clin required or	
Note: Refer to local health pathways or the Australasian Society for HIV, Viral	Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.ashm
INITIATION – Percutaneous exposure Prerequisites (tick box where appropriate) O Patient has percutaneous exposure to blood known to be HIV positive.	ve

I confirm that the above details are correct:

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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:	Name:
Ward:	NHI:

Ledipasvir with sofosbuvir

Note: Only for use in patients with approval by the Hepatitis C Treatment Panel (HepCTP). Applications will be considered by HepCTP at its regular meetings and approved subject to eligibility according to the Access Criteria (set out in Section B of the Pharmaceutical Schedule).

Form RS1108 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Cidofovir			
INITIATION			
Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist, otolaryngologist or oral surgeon, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			

Form RS1109 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:	Name:
Ward:	NHI:
Foscarnet sodium	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

Form RS1110 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 210

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:	Name:
Ward:	NHI:
Ganciclovir	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infection been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

May 2025

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:	Name:		
Ward: NHI:			
Valganciclovir			
INITIATION – Transplant cytomegalovirus prophylaxis Re-assessment required after 3 months Prerequisites (tick box where appropriate) Patient has undergone a solid organ transplant and requires valgan	ciclovir for CMV prophylaxis		
CONTINUATION – Transplant cytomegalovirus prophylaxis Re-assessment required after 3 months Prerequisites (tick boxes where appropriate)			
Patient has undergone a solid organ transplant and recommendate and Patient is to receive a maximum of 90 days of valgancic or	eived anti-thymocyte globulin and requires valganciclovir therapy for elovir prophylaxis following anti-thymocyte globulin		
Patient has received pulse methylprednisolone for acute rejection and requires further valganciclovir therapy for CMV prophylaxis and Patient is to receive a maximum of 90 days of valganciclovir prophylaxis following pulse methylprednisolone			
Hospital.	dance with a protocol or guideline that has been endorsed by the Health NZ		
Patient has undergone a lung transplant			
The donor was cytomegalovirus positive and the patient or The recipient is cytomegalovirus positive	t is cytomegalovirus negative		
O Patient has a high risk of CMV disease			
INITIATION – Cytomegalovirus in immunocompromised patients Prerequisites (tick boxes where appropriate)			
Patient is immunocompromised O Patient has cytomegalovirus syndrome or tissue invasiv or O Patient has rapidly rising plasma CMV DNA in absence or O Patient has cytomegalovirus retinitis			

I confirm that the above details are correct:

May 2025

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:	Name:	
Ward:	NHI:	
Emtricitabine with tenofovir disoproxil		
INITIATION – Confirmed HIV Prerequisites (tick box where appropriate) O Patient has confirmed HIV infection		
INITIATION – Prevention of maternal transmission Prerequisites (tick boxes where appropriate)		
O Prevention of maternal foetal transmission or O Treatment of the newborn for up to eight weeks		
INITIATION – Post-exposure prophylaxis following non-occupational exp Prerequisites (tick boxes where appropriate)	osure to HIV	
Treatment course to be initiated within 72 hours post exposure and		
O Patient has had unprotected receptive anal intercourse vor O Patient has shared intravenous injecting equipment with or O Patient has had non-consensual intercourse and the clir required		
INITIATION – Percutaneous exposure Prerequisites (tick box where appropriate) O Patient has percutaneous exposure to blood known to be HIV positive.	e	
INITIATION – Pre-exposure prophylaxis Re-assessment required after 24 months Prerequisites (tick boxes where appropriate)		
Patient has tested HIV negative, does not have signs or sympt and The Practitioner considers the patient is at elevated risk of HIV	oms of acute HIV infection and has been assessed for HIV seroconversion exposure and use of PrEP is clinically appropriate	
Note: Refer to local health pathways or the Australasian Society for HIV, Viral	Hepatitis and Sexual Health Medicine clinical guidelines (https://ashm.org.au/HIV/F	
CONTINUATION – Pre-exposure prophylaxis Re-assessment required after 24 months Prerequisites (tick boxes where appropriate)		
and	oms of acute HIV infection and has been assessed for HIV seroconversion	
The Practitioner considers the patient is at elevated risk of HIV		
Note: Neter to local nealth pathways or the Australasian Society for HIV, Viral	Hepatitis and Sexual Health Medicine clinical guidelines (https://ashm.org.au/HIV/F	

I confirm that the above details are correct: Signed: Date:

PRES	SCR	IBER		PATIENT:
Name	e:			Name:
Ward:			NHI:	
Ose	ltar	nivir		
INIT Prer			(tick boxes where appropriate)	
	Only for hospitalised patient with known or suspected influenza For prophylaxis of influenza in hospitalised patients as part of a Health NZ Hospital approved infections control plan			a
				a Health NZ Hospital approved infections control plan

PRES	SCR	IBER		PATIENT:						
Name	e:			Name:						
Ward	:			NHI:						
Zanamivir - Powder for inhalation 5 mg										
INITIATION Prerequisites (tick boxes where appropriate)			(tick boxes where appropriate)							
	or O	O	Only for hospitalised patient with known or suspected influenze	a						
		0	For prophylaxis of influenza in hospitalised patients as part of	a Health NZ Hospital approved infections control plan						

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Signed.	Date:	
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Form RS1894 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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PRESCRIBER	PATIENT:					
Name:	Name:					
Ward:	NHI:					
COVID-19 treatments						
INITIATION						
Prerequisites (tick box where appropriate)						
Only if patient meets access criteria (as per https://pharmac.govt.nz/covid-oral-antivirals). Note the supply of treatment is via Pharmac's approved distribution process. Refer to the Pharmac website for more information about this and stock availability						

PRESCRIBER	PATIENT:					
Name:	Name:					
Ward:	NHI:					
Remdesivir						
INITIATION – Treatment of mild to moderate COVID-19 Prerequisites (tick box where appropriate) Only if patient meets access criteria (as per https://pharmac.govt.nz/covid-oral-antivirals). Note the supply of treatment is via Pharmac's approved distribution process. Refer to the Pharmac website for more information about this and stock availability						
INITIATION – COVID-19 in hospitalised patients Re-assessment required after 5 doses Prerequisites (tick boxes where appropriate) O Patient is hospitalised with confirmed (or probal and O Patient is considered to be at high risk of progreand O Patient's symptoms started within the last 7 day and O Patient does not require, or is not expected to reand O Not to be used in conjunction with other funded and O Treatment not to exceed five days	ession to severe disease ys require, mechanical ventilation					

I confirm that the above details are correct:

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Form RS1113 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Interferon gamma	
INITIATION Prerequisites (tick box where appropriate)	
O Patient has chronic granulomatous disease and requires interferon of	gamma



RS1827 - Pegylated interferon alfa-2a

Chronic Hepatitis C - genotype 1 infection treatment more than 4 years prior - INITIATION	219
Chronic hepatitis C - genotype 1 infection - CONTINUATION	219
Chronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV or genotype 2 or 3 pr	ost liver transplant
- INITIATION	219
Chronic hepatitis C - genotype 2 or 3 infection without co-infection with HIV - INITIATION	220
Hepatitis B - INITIATION	220
Myeloproliferative disorder or cutaneous T cell lymphoma - INITIATION	
Myeloproliferative disorder or cutaneous T cell lymphoma - CONTINUATION	221
Ocular surface squamous neoplasia - INITIATION	221
Ocular surface squamous neoplasia - CONTINUATION	
Post-allogenic bone marrow transplant - INITIATION	221
Post-allogenic bone marrow transplant - CONTINUATION	

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

lame:	Name:
/ard:	NHI:
egylated in	terferon alfa-2a
	thronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV or genotype 2 or 3 post liver transplant
	required after 48 weeks tick boxes where appropriate)
	Patient has chronic hepatitis C, genotype 1, 4, 5 or 6 infection
or O	Patient has chronic hepatitis C and is co-infected with HIV
	Patient has chronic hepatitis C genotype 2 or 3 and has received a liver transplant
eatment since onsider reduci	stopping treatment if there is absence of a virological response (defined as at least a 2-log reduction in viral load) following 12 weeks of this is predictive of treatment failure. ng treatment to 24 weeks if serum HCV RNA level at Week 4 is undetectable by sensitive PCR assay (less than 50IU/ml) AND Baseline A is less than 400,000IU/ml.
e-assessment	N – Chronic hepatitis C - genotype 1 infection required after 48 weeks
rerequisites (tick boxes where appropriate)
	ribed by, or recommended by a gastroenterologist, infectious disease specialist or general physician, or in accordance with a protocol or ine that has been endorsed by the Health NZ Hospital.
and and	Patient has chronic hepatitis C, genotype 1
and	Patient has had previous treatment with pegylated interferon and ribavirin
or	O Patient has responder relapsed
	O Patient was a partial responder
and	Patient is to be treated in combination with boceprevir
NITIATION – C	hronic Hepatitis C - genotype 1 infection treatment more than 4 years prior
e-assessment	required after 48 weeks tick boxes where appropriate)
	ribed by, or recommended by a gastroenterologist, infectious disease specialist or general physician, or in accordance with a protocol or ine that has been endorsed by the Health NZ Hospital.
and	Patient has chronic hepatitis C, genotype 1
and	Patient has had previous treatment with pegylated interferon and ribavirin
or	O Patient has responder relapsed
	O Patient was a partial responder
or	O Patient received interferon treatment prior to 2004
and	Patient is to be treated in combination with boceprevir

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

	SCRIBER PATIENT:		
Name:	Name:		
Ward:	:NHI:		
Pegylated interfero	on alfa-2a - continued		
INITIATION – Chronic I Re-assessment required Prerequisites (tick box	hepatitis C - genotype 2 or 3 infection without co-in d after 6 months	fection with HIV	
guideline that Patient I and Patient i and ALT > 2 and HBV DN and Or Se	d after 48 weeks es where appropriate) r, or recommended by a gastroenterologist, infectious di has been endorsed by the Health NZ Hospital. has confirmed Hepatitis B infection (HBsAg positive for is Hepatitis B treatment-naive times Upper Limit of Normal NA < 10 log10 IU/ml BeAg positive	sease specialist or general physician, or in accordance with a protocol or more than 6 months) and significant fibrosis (greater than or equal to Metavir Stage F2 or	
and No conti	insated liver disease tinuing alcohol abuse or intravenous drug use infected with HCV, HIV or HDV ALT nor AST > 10 times upper limit of normal bry of hypersensitivity or contraindications to pegylated	interferon	
INITIATION – myelopro Re-assessment required Prerequisites (tick boxe			
or O Pa	has a cutaneous T cell lymphoma* atient has a myeloproliferative disorder* atient is intolerant of hydroxyurea		
or O Pa	reatment with anagrelide and busulfan is not clinically a atient has a myeloproliferative disorder atient is pregnant, planning pregnancy or lactating	opropriate	

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:	Name:	
Ward:		
Pegylated interferon alfa-2a - continued		
CONTINUATION – myeloproliferative disorder or cutaneous T cell lymphore. Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) No evidence of disease progression and The treatment remains appropriate and patient is benefitting from and Patient has a cutaneous T cell lymphoma* Or Patient has a myeloproliferative disorder* and Or Remains intolerant of hydroxyurea and treat or Patient is pregnant, planning pregnancy or leading to the control or the cont	com treatment com treatment com treatment	
Note: Indications marked with * are unapproved indications		
INITIATION – ocular surface squamous neoplasia Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by an ophthalmologist, or in accordance Hospital. and O Patient has ocular surface squamous neoplasia*	ance with a protocol or guideline that has been endorsed by the Health NZ	
CONTINUATION – ocular surface squamous neoplasia Re-assessment required after 12 months Prerequisites (tick box where appropriate) Prescribed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and The treatment remains appropriate and patient is benefitting from treatment Note: Indications marked with * are unapproved indications		
INITIATION – post-allogenic bone marrow transplant Re-assessment required after 3 months Prerequisites (tick box where appropriate) Patient has received an allogeneic bone marrow transplant* and has evidence of disease relapse		
CONTINUATION – post-allogenic bone marrow transplant Re-assessment required after 3 months Prerequisites (tick box where appropriate) O Patient is responding and ongoing treatment remains appropriate Note: Indications marked with * are unapproved indications		

I confirm that the above details are correct:

Signed: Date:

Musculoskeletal System



PATIENT:
Name:
NHI:

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Zigneg.	i jate:	
Oigilica.	 Duic.	

SCRIBE	ER		PATIENT:		
e:			Name:		
l:			NHI:		
osum	ab				
			porosis oxes where appropriate)		
equisii	163 (lick D	oxes where appropriate)		
and) ·	The p	patient has established osteoporosis		
	or	0	History of one significant osteoporotic fracture demonstrated radiologically, with a documented T-Score less than or equal to -2.5, that incorporates BMD measured using dual-energy x-ray absorptiometry (DEXA)		
	or	0	History of one significant osteoporotic fracture, demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of logistical, technical or pathophysiological reasons		
	or	0	History of two significant osteoporotic fractures demonstrated radiologically		
	or	\bigcirc	O Documented T-Score less than or equal to -3.0		
		0	A 10-year risk of hip fracture greater than or equal to 3%, calculated using a published risk assessment algorithm that incorporates BMD measured using DEXA		
and					
	or	\circ	Bisphosphonates are contraindicated because the patient's creatinine clearance or eGFR is less than 35 mL/min		
		0	The patient has experienced at least two symptomatic new fractures or a BMD loss greater than 2% per year, after at least 12 months' continuous therapy with a funded antiresorptive agent		
	or	0	Bisphosphonates result in intolerable side effects		
	or	0	Intravenous bisphosphonates cannot be administered due to logistical or technical reasons		
			calcaemia oxes where appropriate)		
and)	Patie	nt has hypercalcaemia of malignancy		
(O Patient has severe renal impairment				

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	CRIBER		PATIENT:
Name:			Name:
Ward:			NHI:
Ralox	ifene		
INITIA Prere		s (tick boxes where appropriate)	
	History of one significant osteoporotic fracture demonstrated radiologically and documented bone mineral density (BMD) greater than or equal to 2.5 standard deviations below the mean normal value in young adults (i.e. T-Score less than or equal to -2.5) (see Notes) History of one significant osteoporotic fracture demonstrated radiologically, and either the patient is elderly, or densitometry scanning		
	or \bigcirc	cannot be performed because of major logistical, technical or to many patients under 75 years of age	pathophysiological reasons. It is unlikely that this provision would apply
	or O	History of two significant osteoporotic fractures demonstrated Documented T-Score greater than or equal to -3.0 (see Notes	
	or O	A 10-year risk of hip fracture greater than or equal to 3%, calc Garvan) which incorporates BMD measurements (see Notes)	culated using a published risk assessment algorithm (e.g. FRAX or
	O	Patient has had a Special Authority approval for zoledronic ac approval for alendronate (Underlying cause - Osteoporosis) pr	id (Underlying cause - Osteoporosis) or has had a Special Authority rior to 1 February 2019

Note:

- a) BMD (including BMD used to derive T-Score) must be measured using dual-energy x-ray absorptiometry (DXA).
 Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable.
- b) Evidence suggests that patients aged 75 years and over who have a history of significant osteoporotic fracture demonstrated radiologically are very likely to have a T-Score less than or equal to -2.5 and, therefore, do not require BMD measurement for raloxifene funding.
- c) Osteoporotic fractures are the incident events for severe (established) osteoporosis, and can be defined using the WHO definitions of osteoporosis and fragility fracture. The WHO defines severe (established) osteoporosis as a T-score below -2.5 with one or more associated fragility fractures. Fragility fractures are fractures that occur as a result of mechanical forces that would not ordinarily cause fracture (minimal trauma). The WHO has quantified this as forces equivalent to a fall from a standing height or less.
- d) A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

I confirm that the above details are correct:	
Signed:	Date:

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:		Name:		
Ward:		NHI:		
Teriparatide	•			
	nt required after 18 months (tick boxes where appropriate)			
and	The patient has severe, established osteoporosis			
and	The patient has a documented T-score less than or equal to -3			
and	The patient has had two or more fractures due to minimal trau			
	The patient has experienced at least one symptomatic new fra	cture after at least 12 months' continuous therapy with a funded		

Note:

- a) The bone mineral density (BMD) measurement used to derive the T-score must be made using dual-energy x-ray absorptiometry (DXA). Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable
- b) Antiresorptive agents and their adequate doses for the purposes of this restriction are defined as: alendronate sodium tab 70 mg or tab 70 mg with colecalciferol 5,600 iu once weekly; raloxifene hydrochloride tab 60 mg once daily; zoledronic acid 5 mg per year. If an intolerance of a severity necessitating permanent treatment withdrawal develops during the use of one antiresorptive agent, an alternate antiresorptive agent must be trialled so that the patient achieves the minimum requirement of 12 months' continuous therapy.
- c) A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

I confirm that the above details are correct:	
Signed:	Date:

Form RS1016 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 227

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:	Name:	
Ward:	NHI:	
Rasburicase		
INITIATION		
Prerequisites (tick box where appropriate)		
O Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		

		J1111110	unity funding, see the Special Authority Criteria.
PRESCRIE	BER		PATIENT:
Name:			Name:
Ward:			NHI:
Febuxos	tat		
INITIATIO Prerequis			poxes where appropriate)
and	0	Patie	ent has been diagnosed with gout
	or	0	The patient has a serum urate level greater than 0.36 mmol/l despite treatment with allopurinol at doses of at least 600 mg/day and addition of probenecid at doses of up to 2 g per day or maximum tolerated dose
	or	\bigcirc	The patient has experienced intolerable side effects from allopurinol such that treatment discontinuation is required and serum urate remains greater than 0.36 mmol/l despite use of probenecid at doses of up to 2 g per day or maximum tolerated dose
	or	0	The patient has renal impairment such that probenecid is contraindicated or likely to be ineffective and serum urate remains greater than 0.36 mmol/l despite optimal treatment with allopurinol (see Note)
		0	The patient has previously had an initial Special Authority approval for benzbromarone for treatment of gout.
Re-assess Prerequis	smen sites Preso	t requ (tick t cribed	ur lysis syndrome uired after 6 weeks boxes where appropriate) by, or recommended by a haematologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by the Hospital.
and	\bigcirc		ent is scheduled to receive cancer therapy carrying an intermediate or high risk of tumour lysis syndrome ent has a documented history of allopurinol intolerance
CONTINUATION – Tumour lysis syndrome Re-assessment required after 6 weeks Prerequisites (tick box where appropriate) Prescribed by, or recommended by a haematologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and The treatment remains appropriate and patient is benefitting from treatment			

I confirm that the above details are correct:	
Signed:	Date:

Page 229

PRES	CRIE	BER		PATIENT:
Name	:			Name:
Ward:				NHI:
Suga	ımn	nade	ex.	
INITI. Prere			(tick boxes where appropriate)	
	O Patient requires reversal of profound neuromuscular blockade following rapid sequence induction that has been undertaken using rocuronium (i.e. suxamethonium is contraindicated or undesirable)			
	Severe neuromuscular degenerative disease where the use of neuromuscular blockade is required or Patient has an unexpectedly difficult airway that cannot be intubated and requires a rapid reversal of anaesthesia and neuromuscular blockade or The duration of the patient's surgery is unexpectedly short		neuromuscular blockade is required	
			bated and requires a rapid reversal of anaesthesia and neuromuscular	
	or	0	Neostigmine or a neostigmine/anticholinergic combination is comorbid obesity or COPD)	ontraindicated (for example the patient has ischaemic heart disease,
	or	0	Patient has a partial residual block after conventional reversal	

Form RS1592 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:	Name:
Ward:	NHI:
Etoricoxib	
INITIATION Prerequisites (tick box where appropriate)	
O For in-vivo investigation of allergy only	

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Capsaicin				
INITIATION Prerequisites (tick box where appropriate)				
O Patient has osteoarthritis that is not responsive to paracetamol and oral non-steroidal anti-inflammatories are contraindicated				

Nervous System



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:	Name:
Ward:	NHI:
Riluzole	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a neurologist or respiratory specific by the Health NZ Hospital. The patient has amyotrophic lateral sclerosis with disease during and The patient has at least 60 percent of predicted forced vital calend The patient has not undergone a tracheostomy and The patient has not experienced respiratory failure and The patient is ambulatory The patient is able to use upper limbs The patient is able to swallow	
The patient is able to swallow	
CONTINUATION Re-assessment required after 18 months Prerequisites (tick boxes where appropriate)	
The patient has not undergone a tracheostomy and The patient has not experienced respiratory failure and	
The patient is ambulatory The patient is able to use upper limbs The patient is able to swallow	

I confirm that the above details are correct:

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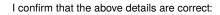
Form RS1763 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 234

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:	Name:
Ward:	NHI:
Sucrose	
INITIATION Prerequisites (tick box where appropriate)	
O For use in neonatal patients only	



Signed: Date:

Page 235

PRES	CRIBER		PATIENT:
Name:			Name:
Ward	:		NHI:
Meth	noxyflur	ane	
	ATION equisites	(tick boxes where appropriate)	
	and	Patient is undergoing a painful procedure with an expected du	ration of less than one hour
		Only to be used under supervision by a medical practitioner or	r nurse who is trained in the use of methoxyflurane

Form RS1146 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 236

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Paracetamol		
INITIATION		
Prerequisites (tick box where appropriate)		
O Intravenous paracetamol is only to be used where other routes are unavailable or impractical, or where there is reduced absorption. The need for IV paracetamol must be re-assessed every 24 hours		

Form RS1145 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 237

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:	Name:
Ward:	NHI:
Capsaicin	
INITIATION Prerequisites (tick box where appropriate)	
O For post-herpetic neuralgia or diabetic peripheral neuropathy	

I confirm that the above details are correct:

Signed: Date:

PRESCRIB	BER	PATIENT:
Name:		Name:
Ward:		NHI:
Vigabatri	in	
	men	t required after 15 months (tick boxes where appropriate)
and	or or	Patient has infantile spasms Patient has epilepsy and Seizures are not adequately controlled with optimal treatment with other antiepilepsy agents or Seizures are controlled adequately but the patient has experienced unacceptable side effects from optimal treatment with other antiepilepsy agents Patient has tuberous sclerosis complex Patient is, or will be, receiving regular automated visual field testing (ideally before starting therapy and on a 6-monthly basis thereafter) It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields
CONTINU. Prerequis		N (tick boxes where appropriate)
and	0	The patient has demonstrated a significant and sustained improvement in seizure rate or severity and or quality of life
ana	or	O Patient is receiving regular automated visual field testing (ideally every 6 months) on an ongoing basis for duration of treatment with vigabatrin
	OI OI	O It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields

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Signed.	Date:	
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May 2025

following: sodium valproate, topiramate, levetiracetote: Those of childbearing potential are not required to trial phenyquired to trial sodium valproate. DNTINUATION erequisites (tick box where appropriate)	
Patient has demonstrated a significant and sustained imp	NHI:
Patient has demonstrated a significant and sustained imp	
Patient has focal epilepsy Seizures are not adequately controlled by, or patient following: sodium valproate, topiramate, levetiracet. Those of childbearing potential are not required to trial phenyquired to trial sodium valproate. DNTINUATION Rerequisites (tick box where appropriate) Patient has demonstrated a significant and sustained imp	
Patient has focal epilepsy Seizures are not adequately controlled by, or patient following: sodium valproate, topiramate, levetiracet. Those of childbearing potential are not required to trial phenyquired to trial sodium valproate. DNTINUATION Perequisites (tick box where appropriate) Patient has demonstrated a significant and sustained imp	
Patient has focal epilepsy and Seizures are not adequately controlled by, or patient following: sodium valproate, topiramate, levetiracetote: Those of childbearing potential are not required to trial phenyquired to trial sodium valproate. DNTINUATION Perequisites (tick box where appropriate) Patient has demonstrated a significant and sustained imp	
cite: Those of childbearing potential are not required to trial pheny quired to trial sodium valproate. DNTINUATION rerequisites (tick box where appropriate) Patient has demonstrated a significant and sustained imp	nt has experienced unacceptable side effects from, optimal treatment with all of the
erequisites (tick box where appropriate) O Patient has demonstrated a significant and sustained imp	tam, and any two of carbamazepine, lamotrigine, and phenytoin sodium (see Note) ytoin sodium, sodium valproate, or topiramate. Those who can father children are not
O Patient has demonstrated a significant and sustained imp	
starting lacosamide treatment	provement in seizure rate or severity and/or quality of life compared with that prior to

I confirm that the above details are correct:

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Oigilica.	 Duic.	

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:
Stiri	pentol
Re-a	ATION ssessment required after 6 months equisites (tick boxes where appropriate) Prescribed by, or recommended by a paediatric neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	Patient has confirmed diagnosis of Dravet syndrome Seizures have been inadequately controlled by appropriate courses of sodium valproate, clobazam and at least two of the following: topiramate, levetiracetam, ketogenic diet
	: Those of childbearing potential are not required to trial sodium valproate or topiramate. Those who can father children are not required to trial um valproate.
	TINUATION equisites (tick box where appropriate) Prescribed by, or recommended by a paediatric neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health
and (NZ Hospital. Patient continues to benefit from treatment as measured by reduced seizure frequency from baseline

I confirm that the above details are correct:

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Signeg.	 Date:	
Cigilou.	 Date.	

PRESCRIBER		PATIENT:
Name:		Name:
Ward:		NHI:
Hyoscine hy	drobromide - Patch 1.5 mg	
or O	patient cannot tolerate or does not adequately respond to oral Control of clozapine-induced hypersalivation where trials of at	

I confirm that the above details are correct:		
Signed:	Date:	

Form RS1154 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Aprepitant		
INITIATION Prerequisites (tick box where appropriate)		
O Patient is undergoing highly emetogenic chemotherapy and/or anthracycline-based chemotherapy for the treatment of malignancy		

PRESC	RIBER	PATIENT:
Name:		Name:
Ward: .		NHI:
Palipe	ridone	
	essment required after 12 months uisites (tick boxes where appropriate) The patient has had an initial Special Authority approval for adepot injection The patient has schizophrenia or other psychotic disorand The patient has been unable to adhere to treatment usand	
Re-ass	NUATION essment required after 12 months uisites (tick box where appropriate)	
0	The initiation of paliperidone depot injection has been associated corresponding period of time prior to the initiation of an atypical an	with fewer days of intensive intervention than was the case during a tipsychotic depot injection

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Zigneg.	i jate:	
Oigilica.	 Duic.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Paliperidone palmitate	
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
The patient has schizophrenia and The patient has had an initial Special Authority approval for pa	aliperidone once-monthly depot injection
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate) The initiation of paliperidone depot injection has been associated wi corresponding period of time prior to the initiation of an atypical antip	th fewer days of intensive intervention than was the case during a psychotic depot injection

I confirm that the above details are correct:

C:	D-1	
Signed.	Date:	
Oigilica.	 Daic.	

Form RS2018 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 245

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:	Name:			
Ward:	NHI:			
Olanzapine				
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate)				
O The initiation of olanzapine depot injection has been associated with fewer days of intensive intervention than was the case during a				

I confirm that the above details are correct:

Signed: Date:

PRES	CRII	BER													F	TENT:	
Name:	:														١	ne:	
Ward:															1	:	
Rispe	erid	lone															
INITIA Re-as Prere	sses	smen	The depo	pati pati ot in Th	es when the second seco	as han	ad an has has	opria n initi schiz not b	zophre een a	renia da la	or oth	ner psy here to	ychotic o treatm	disord	der sin	done depot injection or olanzapine depot injection of a control of the control of	
CONT Re-as	sses	smen	t requ)						4		
)	The i	nitiati	on d	of risp	erido	one o	depot	t injec							er days of intensive intervention than was the cas otic depot injection	se during a

0:	D - 1 - 1	
Zigneg.	i jate:	
Oigilica.	 Duic.	

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.

PRESCRI	BER			PATIENT:			
Name:				Name:			
Ward:				NHI:			
Aripipra	zole						
Prerequi:		O The		al for risperidone depot injection or paliperidone depot injection or			
	or	and and		c disorder pical antipsychotic agents but has been unable to adhere ated in respite care, or intensive outpatient or home-based treatment for			
or	0	Patient has	s been unable to access olanzapine depot injectic	n due to supply issues with olanzapine depot injection, or otherwise would			

Note below for the olanzapine Special Authority criteria for new olanzapine depot injection patients prior to 1 April 2024)

Note: The Olanzapine depot injection Special Authority criteria that apply to criterion 2 in this Aripiprazole Special Authority application are as follows:

have been initiated on olanzapine depot injection but has been unable to due to supply issues with olanzapine depot injection. (see

- The patient has had an initial Special Authority approval for paliperidone depot injection or risperidone depot injection; or
- All of the following:
 - · The patient has schizophrenia; and
 - The patient has tried but has not been able to adhere with treatment using oral atypical antipsychotic agents; and
 - The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in the last 12 months.

I confirm that the above details are correct:		
Signed:	Date:	

Page 248

PRESCR	IBER	PATIENT:
Name:		Name:
Ward:		NHI:
Diazepa	am	
INITIATI Prerequ	ON isites (tick box where appropriate)	
0	Prescribed by, or recommended by a relevant specialist, or in accord Hospital.	dance with a protocol or guideline that has been endorsed by the Health NZ
and	Only for use in children where diazepam tablets are not appropriate	

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.

I confirm that the above details are correct:

Signed: Date:

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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:	Name:					
Ward:	NHI:					
Multiple Sclerosis - continued						
CONTINUATION – Multiple Sclerosis - dimethyl fumarate, fingolimod, glatiramer acetate, interferon beta-1-alpha, interferon beta-1-beta, natalizumab and teriflunomide						
Prerequisites (tick box where appropriate)						
O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the NZ Hospital.						
Patient has had an EDSS score of 0 to 6.0 (inclusive) with or without the use unilateral or bilateral aids at any time in the last six months the patient has walked 100 metres or more with or without aids in the last six months. Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.						

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.

	PATIENT: Name:
	NHI:
ple Sclerosis	
ATION – Multiple Sclerosis ssessment required after 12 equisites (tick boxes where a Prescribed by, or recom NZ Hospital.	months
and Patient has and	an EDSS score between 0 – 6.0 had at least one significant attack of MS in the previous 12 months or two significant attacks in the past 24 months
neces featur and Each exper and Each attack and Each 37.5°c and Or	Each significant attack is severe enough to change either the EDSS or at least one of the Kurtze Functional System scores by at least 1 point Each significant attack is a recurrent paroxysmal symptom of multiple sclerosis (tonic seizures/spasms,
and Evidence of and A sign lesion or A sign or A sign or A sign recen or	new inflammatory activity on an MRI scan within the past 24 months of that new inflammatory activity on MRI scanning (in criterion 5 immediately above) is a gadolinium enhancing of that new inflammatory activity is a lesion showing diffusion restriction of that new inflammatory is a T2 lesion with associated local swelling of that new inflammatory activity is a prominent T2 lesion that clearly is responsible for the clinical features of a tattack that occurred within the last 2 years of that new inflammatory activity is new T2 lesions compared with a previous MRI scan
or O Patient has an act	ive Special Authority approval for either dimethyl fumarate, fingolimod, glatiramer acetate, interferon beta-1-alpha, peta, natalizumab or teriflunomide

I confirm that the above details are correct:

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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.

Schedule. For community funding, see the Special Authority Criteria.								
PRESCRIBER	PATIENT:							
Name:	Name:							
Ward:	NHI:							
Multiple Sclerosis - continued								
CONTINUATION – Multiple Sclerosis - ocrelizumab Prerequisites (tick box where appropriate)								
O Prescribed by, or recommended by any relevant practitioner, or in ac NZ Hospital.	cordance with a protocol or guideline that has been endorsed by the Health							
INITIATION – Primary Progressive Multiple Sclerosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)								
O Prescribed by, or recommended by any relevant practitioner, or in ac NZ Hospital.	ecordance with a protocol or guideline that has been endorsed by the Health							
	eets the 2017 McDonald criteria and has been confirmed by a							
	Patient has an EDSS 2.0 (score equal to or greater than 2 on pyramidal functions) to EDSS 6.5							
O Patient has no history of relapsing remitting multiple sclerosis								
CONTINUATION – Primary Progressive Multiple Sclerosis Prerequisites (tick box where appropriate)								
NZ Hospital.	scordance with a protocol or guideline that has been endorsed by the Health							
Patient has had an EDSS score of less than or equal to 6.5 at any ti assistance/aids, without rest in the last six months)	me in the last six months (ie patient has walked 20 metres with bilateral							

I confirm that the above details are correct:

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PRESCRIBER		PATIENT:
Name:		Name:
Ward:		NHI:
Melatonin		
Re-assessment ro Prerequisites (tide Prescrib guideline and Prescrib guideline and	ne that has been endorsed by the Health NZ Hospital.	r are inappropriate
Re-assessment re Prerequisites (tide) Prescrib	I – insomnia secondary to neurodevelopmental disorder required after 12 months ck boxes where appropriate) bed by, or recommended by a psychiatrist, paediatrician, neurone that has been endorsed by the Health NZ Hospital.	rologist or respiratory specialist, or in accordance with a protocol or
and Pand	Patient is aged 18 years or under Patient has demonstrated clinically meaningful benefit from fur Patient has had a trial of funded modified-release melatonin dersistent and distressing insomnia Funded modified-release melatonin is to be given at doses no	scontinuation within the past 12 months and has had a recurrence of
INITIATION _ inc	somnia where benzodiazepines and zopiclone are contra ck boxes where appropriate)	indicated

I confirm that the above details are correct:	
Signed:	Date:

PRESCRI	BER		PATIENT:
Name:			Name:
Ward:			NHI:
Nusiner	sen		
	sment	required after 12 months (tick boxes where appropriate)	
and	O	Patient has genetic documentation of homozygous SMN1 geneterozygous mutation Patient is 18 years of age or under	ne deletion, homozygous SMN1 point mutation, or compound
	or	Patient has experienced the defined signs and symptom Patient is pre-symptomatic and Patient has three or less copies of SMN2	as of SMA type I, II or IIIa prior to three years of age
	sment	N required after 12 months (tick boxes where appropriate)	
and		There has been demonstrated maintenance of motor mileston Patient does not require invasive permanent ventilation (at lea while being treated with nusinersen Nusinersen not to be administered in combination other SMA	st 16 hours per day), in the absence of a potentially reversible cause

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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:	Name:
Ward:	NHI:
Risdiplam	
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
Patient has genetic documentation of homozygous SMN1 genetic documentation of	
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
	e function since treatment initiation st 16 hours per day), in the absence of a potentially reversible cause
and Risdiplam not to be administered in combination other SMA di	sease modifying treatments or gene therapy
Patient is 18 years of age or under O Patient has experienced the defined signs and symptom or Patient is pre-symptomatic and Patient has three or less copies of SMN2 CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) There has been demonstrated maintenance of motor mileston and Patient does not require invasive permanent ventilation (at lear while being treated with risdiplam	e function since treatment initiation st 16 hours per day), in the absence of a potentially reversible cause

I confirm that the above details are correct:

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May 2025

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Modafinil	
INITIATION – Narcolepsy Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by a neurologist or respiratory spe by the Health NZ Hospital.	cialist, or in accordance with a protocol or guideline that has been endorsed
The patient has a diagnosis of narcolepsy and has exc daily for three months or more	essive daytime sleepiness associated with narcolepsy occurring almost
or The patient has a multiple sleep latency test with more sleep onset rapid eye movement periods The patient has at least one of: cataplexy, sleep	a mean sleep latency of less than or equal to 10 minutes and 2 or paralysis or hypnagogic hallucinations
An effective dose of a listed formulation of methy because of intolerable side effects Methylphenidate and dexamphetamine are contr	Iphenidate or dexamphetamine has been trialled and discontinued aindicated
O Patient meets the Hospital Restriction criteria for methy and Patient is unable to access methylphenidate hydrochlo	
Note: Criterion 2 is to permit short-term funding to cover an out-of-stock of m	

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Signed.	Date:	
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PRESCRIBER	PATIE	NT:
Name:	Name	:
Ward:	NHI:	
isdexamfetamine di	mesilate	
INITIATION Prerequisites (tick boxes v	where appropriate)	
	recommended by a paediatrician or psychiatrist, or in acc	ordance with a protocol or guideline that has been endorsed by the
or O ADHI and Diagrand O or O or O or O or O and	and has not received sufficient benefit or has experienced. Patient is taking a currently subsidised formulation of dexeffective due to significant administration and/or treatmer. There is significant concern regarding the risk of diversion. Patient is taking a currently subsidised formulation of merelease) which has not been effective due to significant at a significant concern regarding the risk of diversion. Patient would have been prescribed a subsidised for but has been unable to access due to supply issue.	moxetine or methylphenidate hydrochloride (extended-release) d intolerable side effects amfetamine sulfate (immediate-release) which has not been it adherence difficulties n or abuse of immediate release dexamfetamine sulfate hylphenidate hydrochloride (immediate-release or sustained dministration and/or treatment adherence difficulties n or abuse of immediate release methylphenidate hydrochloride ormulation of methylphenidate hydrochloride (extended-release) is with methylphenidate hydrochloride (extended-release) enidate or dexamfetamine) are not appropriate

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Signed.	Date:	
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May 2025

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:	Name:		
Ward:	NHI:		
Methylphenidate hydrochloride			
INITIATION – ADHD (immediate-release and sustained-release Prerequisites (tick box where appropriate)	formulations)		
Health NZ Hospital.	rchiatrist, or in accordance with a protocol or guideline that has been endorsed by the sorder), diagnosed according to DSM-IV or ICD 10 criteria		
INITIATION – Narcolepsy (immediate-release and sustained-release) Prerequisites (tick box where appropriate)	lease formulations)		
Prescribed by, or recommended by a neurologist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. Patient suffers from narcolepsy			
and			
And O Patient suffers from narcolepsy INITIATION – Extended-release and modified-release formulation Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a paediatrician or psy Health NZ Hospital.	rchiatrist, or in accordance with a protocol or guideline that has been endorsed by the		
Patient suffers from narcolepsy INITIATION – Extended-release and modified-release formulation Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a paediatrician or psy Health NZ Hospital. Patient has ADHD (Attention Deficit and Hyperactive)			
Patient suffers from narcolepsy INITIATION – Extended-release and modified-release formulating Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a paediatrician or psy Health NZ Hospital. Patient has ADHD (Attention Deficit and Hyperactive and Patient is taking a currently listed formulation has not been effective due to significant admit	orchiatrist, or in accordance with a protocol or guideline that has been endorsed by the vity Disorder), diagnosed according to DSM-IV or ICD 10 criteria of methylphenidate hydrochloride (immediate-release or sustained-release) which		
Patient suffers from narcolepsy INITIATION – Extended-release and modified-release formulating Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a paediatrician or psy Health NZ Hospital. Patient has ADHD (Attention Deficit and Hyperactive and Patient is taking a currently listed formulation has not been effective due to significant admit or	orchiatrist, or in accordance with a protocol or guideline that has been endorsed by the vity Disorder), diagnosed according to DSM-IV or ICD 10 criteria of methylphenidate hydrochloride (immediate-release or sustained-release) which		
Patient suffers from narcolepsy INITIATION – Extended-release and modified-release formulating Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a paediatrician or psy Health NZ Hospital. Patient has ADHD (Attention Deficit and Hyperactive and Patient is taking a currently listed formulation has not been effective due to significant admit or There is significant concern regarding the risk INITIATION – Narcolepsy* (extended-release only) Prerequisites (tick box where appropriate)	of methylphenidate hydrochloride (immediate-release or sustained-release) which inistration and/or compliance difficulties		

I confirm that the above details are correct:

Signed: Date:

PRESCRIBI	ER	PATIENT:
Name:		Name:
Ward:		NHI:
Dexamph	netamine sulphate	
O P	ites (tick box where appropriate)	r in accordance with a protocol or guideline that has been endorsed by the gnosed according to DSM-IV or ICD 10 criteria
Prerequisi P by	N - Narcolepsy ites (tick box where appropriate) Prescribed by, or recommended by a neurologist or respiratory spec by the Health NZ Hospital. Patient suffers from narcolepsy	ialist, or in accordance with a protocol or guideline that has been endorsed

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:	Name:
Ward:	NHI:
Rivastigmine	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
The patient has been diagnosed with dementia and The patient has experienced intolerable nausea and/or vomiting	ng from donepezil tablets
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
The treatment remains appropriate The patient has demonstrated a significant and sustained ben	efit from treatment

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Naltrexone hydrochloride	
INITIATION – Alcohol dependence Prerequisites (tick boxes where appropriate) O Patient is currently enrolled, or is planned to be enrolled, in a rand O Naltrexone is to be prescribed by, or on the recommendation of	recognised comprehensive treatment programme for alcohol dependence of, a physician working in an Alcohol and Drug Service
INITIATION – Constipation Prerequisites (tick box where appropriate) Or For the treatment of opioid-induced constipation	

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Signed.	Date:	
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PRES	CRI	BER		PATIENT:
Name	:			Name:
Ward:				NHI:
Nico	tine)		
INITIA Prere			(tick boxes where appropriate)	
		0	For perioperative use in patients who have a 'nil by mouth' inst	truction
	or	0	For use within mental health inpatient units	
	O Patient would be admitted to a mental health inpatient unit, but is unable to due to COVID-19 self-isolation requirement			
	O For acute use in agitated patients who are unable to leave the hospital facilities			

PRESCRI	BER	PATIENT:
Name:		
Ward:		NHI:
Varenicl	ine	
INITIATIC Prerequis		(tick boxes where appropriate)
and	0	Short-term therapy as an aid to achieving abstinence in a patient who has indicated that they are ready to cease smoking The patient is part of, or is about to enrol in, a comprehensive support and counselling smoking cessation programme, which includes prescriber or nurse monitoring
	or	The patient has tried but failed to quit smoking after at least two separate trials of nicotine replacement therapy, at least one of which included the patient receiving comprehensive advice on the optimal use of nicotine replacement therapy The patient has tried but failed to quit smoking using bupropion or nortriptyline
and	0	The patient has not had a Special Authority for varenicline approved in the last 6 months Varenicline is not to be used in combination with other pharmacological smoking cessation treatments and the patient has agreed to this
and	\circ	The patient is not pregnant The patient will not be prescribed more than 12 weeks' funded varenicline in a 12 month period

PRESCRIBER		PATIENT:
Name:		Name:
Ward:		NHI:
Buprenorph	ine with naloxone	
INITIATION – Prerequisites	Detoxification (tick boxes where appropriate)	
Patient is opioid dependent O Patient is currently engaged with an opioid treatment service approved by the Ministry of Health O Prescriber works in an opioid treatment service approved by the Ministry of Health		
	Maintenance treatment (tick boxes where appropriate)	
and and	Patient is opioid dependent Patient will not be receiving methadone	
and	Patient is currently enrolled in an opioid substitution treatment Prescriber works in an opioid treatment service approved by the	

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Signed.	Date:	
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Oncology Agents and Immunosuppressants



May 2025

PRESCRIBER		PATIENT:
Name:		Name:
Ward:		NHI:
Bendamustine hydro	ochloride	
INITIATION – CLL* Prerequisites (tick boxes	where appropriate)	
and Patient has	nt has chronic lymphocytic leukaemia requiring treations ECOG performance status 0-2 stine is to be administered at a maximum dose of 10	ment 10 mg/m ² on days 1 and 2 every 4 weeks for a maximum of 6 cycles
		hronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma
INITIATION – Indolent, Lo Re-assessment required a Prerequisites (tick boxes	after 9 months where appropriate)	
and Patient has and or or and or	Patient is refractory to or has relapsed within 12 n regimen Bendamustine is to be administered in combination. The patient has not received prior bendamustine to the second s	herapy m of 6 cycles in relapsed patients (in combination with rituximab when l of 12 months or more

I confirm that the above details are correct:	
Signed:	Date:

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.

PRESCRIBE	ER	PATIENT:	
Name:		Name:	
Ward:		NHI:	
Bendamus	stine hydrochloride - continued		
Re-assessm	TION – Indolent, Low-grade lymphomas nent required after 9 months es (tick boxes where appropriate)		
	Patient is refractory to or has relapsed within 12 months and Bendamustine is to be administered in combination with		
or	O Patients have not received a bendamustine regimen with and	nin the last 12 months	
	rituximab when CD20+) and Patient has had a rituximab treatment-free in	example for a maximum of 6 cycles in relapsed patients (in combination with	
Note: 'indole	ent, low-grade lymphomas' includes follicular, mantle cell, margina	l zone and lymphoplasmacytic/ Waldenström's macroglobulinaemia.	
Re-assessm Prerequisite	- Hodgkin's lymphoma* nent required after 6 months es (tick boxes where appropriate) Patient has Hodgkin's lymphoma requiring treatment		
and	Patient has a ECOG performance status of 0-2		
and	Patient has received one prior line of chemotherapy Patient's disease relapsed or was refractory following prior che	emotherapy	
	O Bendamustine is to be administered in combination with gemcitabine and vinorelbine (BeGeV) at a maximum dose of no greater than 90 mg/m2 twice per cycle, for a maximum of four cycles		
Note: Indica	ations marked with * are unapproved indications.		

I confirm that the above details are correct:

Signed: Date:

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:	Name:
Ward:	NHI:
Azacitidine	
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
The individual has intermediate or high risk MDS based The individual has chronic myelomonocytic leukaemia (to recognised scoring system or 10%-29% marrow blasts where the individual has acute myeloid leukaemia according to and The individual has an estimated life expectancy of at least 3 mm	pased on an intermediate or high risk score from an internationally vithout myeloproliferative disorder) b World Health Organisation (WHO) Classification
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate)	
Prerequisites (tick box where appropriate) O No evidence of disease progression	

I confirm that the above details are correct:

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Mercaptopurine	
INITIATION Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a paediatric haematologist or pabeen endorsed by the Health NZ Hospital. and O The patient requires a total dose of less than one full 50 mg tablet pages.	ediatric oncologist, or in accordance with a protocol or guideline that has er day
been endorsed by the Health NZ Hospital.	ediatric oncologist, or in accordance with a protocol or guideline that has
The patient requires a total dose of less than one full 50 mg tablet po	er day

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:	nme:	
Ward:		NHI:
Venetoclax		
Re-assessmer	relapsed/refractory chronic lymphocytic leukaemia nt required after 7 months (tick boxes where appropriate)	
Trerequiones	(tion boxes where appropriate)	
and	Individual has chronic lymphocytic leukaemia requiring treatr Individual has received at least one prior therapy for chronic	
and	Individual has not previously received funded venetoclax	y p coj no . co do
and and	The individual's disease has relapsed	
and	Venetoclax to be used in combination with six 28-day cycles venetoclax	of rituximab commencing after the 5-week dose titration schedule with
	Individual has an ECOG performance status of 0-2	
and	(tick boxes where appropriate) Treatment remains clinically appropriate and the individual is Venetoclax is to be discontinued after a maximum of 24 mont is required due to disease progression or unacceptable toxici	ths of treatment following the titration schedule unless earlier discontinuation
Re-assessmer	previously untreated chronic lymphocytic leukaemia with at required after 6 months (tick boxes where appropriate)	17p deletion or TP53 mutation*
and	Individual has previously untreated chronic lymphocytic leuka	aemia
and	There is documentation confirming that the individual has 17	p deletion by FISH testing or TP53 mutation by sequencing
O	Individual has an ECOG performance status of 0-2	
Re-assessmer Prerequisites No e Note: 'Chronic	ON – previously untreated chronic lymphocytic leukaemia and required after 6 months (tick box where appropriate) vidence of disease progression lymphocytic leukaemia (CLL)' includes small lymphocytic lymphare unapproved indications	with 17p deletion or TP53 mutation* phoma (SLL)* and B-cell prolymphocytic leukaemia (B-PLL)*. Indications

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	CRIE	BER	PATIENT:
Name):		Name:
Ward	d:NHI:		NHI:
Vene	etocl	ax - continued	
		N – previously untreated acute myeloid leukaemia	
		sites (tick boxes where appropriate)	
	or	O The individual is currently on treatment with venetoclax and m	et all remaining special authority criteria prior to commencing treatment
	O Individual has previously untreated acute myeloid leukaemia (see note a), according to World Health Organization (WHO) Classification		
	O Venetoclax not to be used in combination with standard intensive remission induction chemotherapy and		
		O Venetoclax to be used in combination with azacitidine or	low dose cytarabine
Re-a	ssess	ATION – previously untreated acute myeloid leukaemia sment required after 6 months sites (tick box where appropriate)	
(Note		No evidence of disease progression	
a) 'A	cute	myeloid leukaemia' includes myeloid sarcoma*	
b) Ir	ndicat	ions marked with * are Unapproved indications	

Signed: Date:

PRES	CRIB	ER			PATIENT:
Name	:				Name:
Ward:					NHI:
Olap	arib				
Re-a	ssess equisi	ment ites (tick boxes	fter 12 months where appropriate)	dance with a protocol or guideline that has been endorsed by the Health NZ
	and (and	$\overline{}$		s a high-grade serous* epithelial ovarian, fallopian tu	
			and O	Patient has newly diagnosed, advanced disease Patient has received one line** of previous treatment Patient's disease must have experienced a partial	ent with platinum-based chemotherapy or complete response to the first-line platinum-based regimen
		or	and and and	the penultimate line** of platinum-based chemothe	disease progression occurring at least 6 months after the last dose of erapy or complete response to treatment with the immediately preceding
	and and (and and) ·	Treatment	will be commenced within 12 weeks of the patient's to be administered as maintenance treatment not to be administered in combination with other che	last dose of the immediately preceding platinum-based regimen emotherapy

I confirm that the above details are correct:	
Signed:	Date:

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:	Name:
Ward:	NHI:
Olaparib - continued	
CONTINUATION – Ovarian cancer Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by a medical oncologist, or in according Hospital.	rdance with a protocol or guideline that has been endorsed by the Health NZ
Treatment remains clinically appropriate and patient is benefit	ting from treatment
or No evidence of progressive disease Evidence of residual (not progressive) disease and the opinion	patient would continue to benefit from treatment in the clinician's
and Treatment to be administered as maintenance treatment and Treatment not to be administered in combination with other ch	
	ent with platinum-based chemotherapy en informed and acknowledges that the funded treatment period of le patient experiences a complete response to treatment and there is
O Patient has received at least two lines** of previous trea	atment with platinum-based chemotherapy

Note: *Note "high-grade serous" includes tumours with high-grade serous features or a high-grade serous component.
**A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments.

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER		PATIENT:
Name:		Name:
Ward:		NHI:
Ibrutinib		
Re-assessme Prerequisites and and and on and on on	Individual has received at least one prior immunocand Individual's CLL has relapsed and Individual has experienced intolerable side effects	ual has 17p deletion or TP53 mutation with venetoclax monotherapy chemotherapy for CLL with venetoclax in combination with rituximab regimen
Prerequisites	nt required after 12 months (tick box where appropriate)	
Note: 'Chron	evidence of clinical disease progression ic lymphocytic leukaemia (CLL)' includes small lymphocytic lymph	noma (SLL) and B-cell prolymphocytic
ieukaeiiila (E	3-PLL)*. Indications marked with * are Unapproved indications.	

I confirm that the above details are correct:	
Signed:	Date:

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.

NAME: NHI: NHI: In thas advanced high-grade serous* epithelial ovarian, fallopian tube, or primary peritoneal cancer In thas received at least one line** of treatment with platinum-based chemotherapy In thas experienced a partial or complete response to the preceding treatment with platinum-based chemotherapy In thas not previously received funded treatment with a PARP inhibitor Treatment will be commenced within 12 weeks of the patient's last dose of the preceding platinum-based regimen
red after 6 months oxes where appropriate) In thas advanced high-grade serous* epithelial ovarian, fallopian tube, or primary peritoneal cancer In thas received at least one line** of treatment with platinum-based chemotherapy In thas experienced a partial or complete response to the preceding treatment with platinum-based chemotherapy In that not previously received funded treatment with a PARP inhibitor
oxes where appropriate) In thas advanced high-grade serous* epithelial ovarian, fallopian tube, or primary peritoneal cancer In thas received at least one line** of treatment with platinum-based chemotherapy In that has experienced a partial or complete response to the preceding treatment with platinum-based chemotherapy In that not previously received funded treatment with a PARP inhibitor
oxes where appropriate) In thas advanced high-grade serous* epithelial ovarian, fallopian tube, or primary peritoneal cancer In thas received at least one line** of treatment with platinum-based chemotherapy In that has experienced a partial or complete response to the preceding treatment with platinum-based chemotherapy In that not previously received funded treatment with a PARP inhibitor
nt has received at least one line** of treatment with platinum-based chemotherapy nt has experienced a partial or complete response to the preceding treatment with platinum-based chemotherapy nt has not previously received funded treatment with a PARP inhibitor
Patient commenced treatment with niraparib prior to 1 May 2024
ment to be administered as maintenance treatment ment not to be administered in combination with other chemotherapy
red after 6 months expected after 6 months e
ment to be administered as maintenance treatment ment not to be administered in combination with other chemotherapy
Treatment with niraparib to cease after a total duration of 36 months from commencement Treatment with niraparib is being used in the second-line or later maintenance setting
ro

Note: * "high-grade serous" includes tumours with high-grade serous features or a high-grade serous component.

**A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments

May 2025

PRESCRIBER	PATIENT:
Name:	Name:
Nard:	NHI:
_enalidomide	
INITIATION – Plasma cell dyscrasia Prerequisites (tick boxes where appropriate)	r or in accordance with a protocol or guideling that has been endersed by the Health
and Patient has plasma cell dyscrasia, not including Walde and Patient is not refractory to prior lenalidomide use	r, or in accordance with a protocol or guideline that has been endorsed by the Health enström macroglobulinaemia, requiring treatment
INITIATION – Myelodysplastic syndrome Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by any relevant practitioner NZ Hospital.	r, or in accordance with a protocol or guideline that has been endorsed by the Health
	c syndrome (based on IPSS or an IPSS-R score of less than 3.5) associated with
CONTINUATION – Myelodysplastic syndrome Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any relevant practitioner NZ Hospital. and	r, or in accordance with a protocol or guideline that has been endorsed by the Health
O Patient has not needed a transfusion in the last 4 mor and O No evidence of disease progression	nths

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pomalidomide	
NZ Hospital.	cordance with a protocol or guideline that has been endorsed by the Health acluding Waldenström macroglobulinaemia, requiring treatment
CONTINUATION – Relapsed/refractory plasma cell dyscrasia Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by any relevant practitioner, or in act NZ Hospital. and O Patient has no evidence of disease progression	cordance with a protocol or guideline that has been endorsed by the Health

I confirm that the above details are correct:		
Signed:	Date:	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Temozolomide	
INITIATION – gliomas Re-assessment required after 12 months Prerequisites (tick box where appropriate) Patient has a glioma	
CONTINUATION – gliomas Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Treatment remains appropriate and patient is benefitting from treatment	nent
INITIATION – Neuroendocrine tumours Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)	
Patient has been diagnosed with metastatic or unresectable wand Temozolomide is to be given in combination with capecitabine and Temozolomide is to be used in 28 day treatment cycles for a new per day and Temozolomide to be discontinued at disease progression	
CONTINUATION – Neuroendocrine tumours Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) No evidence of disease progression and	
The treatment remains appropriate and the patient is benefitting	ng from treatment
INITIATION – ewing's sarcoma Re-assessment required after 9 months Prerequisites (tick box where appropriate) O Patient has relapse or refractory Ewing's sarcoma	
CONTINUATION – ewing's sarcoma Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
No evidence of disease progression and The treatment remains appropriate and the patient is benefitting	ng from treatment
Note: Indication marked with a * is an unapproved indication. Temozolomic relapsed high grade glioma.	de is not funded for the treatment of

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Thalidomide		
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Or The patient has plasma cell dyscrasia, not including Waldenst or The patient has erythema nodosum leprosum	röm macroglobulinaemia, requiring treatment	
CONTINUATION Prerequisites (tick box where appropriate) O Patient has obtained a response from treatment during the initial approval period Note: Prescription must be written by a registered prescriber in the thalidomide risk management programme operated by the supplier Maximum dose of 400 mg daily as monotherapy or in a combination therapy regimen		

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Signed.	Date:	
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Form RS2043 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:	Name:
Ward:	NHI:
Bortezomib	
INITIATION – plasma cell dyscrasia Prerequisites (tick box where appropriate)	
O The patient has plasma cell dyscrasia, not including Waldenström m	nacroglobulinaemia, requiring treatment

I confirm that the above details are correct:

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May 2020

PRECORINER	DATIFAIT
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pegaspargase	
INITIATION – Newly diagnosed ALL Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
The patient has newly diagnosed acute lymphoblastic leukaem and Pegaspargase to be used with a contemporary intensive multi-	
INITIATION – Relapsed ALL Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
The patient has relapsed acute lymphoblastic leukaemia and Pegaspargase to be used with a contemporary intensive multi-	ragent chemotherapy treatment protocol
INITIATION – Lymphoma Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Patient has lymphoma requiring L-asparaginase containing protocol	(e.g. SMILE)

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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:	Name:
Ward:	NHI:
Nilotinib	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by a haematologist, or in accordan Hospital.	ce with a protocol or guideline that has been endorsed by the Health NZ
Patient has a diagnosis of chronic myeloid leukaemia (CML) i	n blast crisis, high risk chronic phase, or in chronic phase
O Patient has documented CML treatment failure* with a t	yrosine kinase inhibitor (TKI)
O Patient has experienced treatment limiting toxicity with a	a tyrosine kinase inhibitor (TKI) precluding further treatment
and Maximum nilotinib dose of 800 mg/day and	
O Subsidised for use as monotherapy only	
Note: *treatment failure as defined by Leukaemia Net Guidelines.	
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by a haematologist, or in accordan Hospital.	ce with a protocol or guideline that has been endorsed by the Health NZ
Lack of treatment failure while on nilotinib as defined by Leuk	aemia Net Guidelines
O Nilotinib treatment remains appropriate and the patient is ben and	efiting from treatment
O Maximum nilotinib dose of 800 mg/day	
O Subsidised for use as monotherapy only	

I confirm that the above details are correct:

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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	CRIB	ER	PATIENT:
Name	e:		
Ward	:		NHI:
Rux	olitin	ib	
Re-a		ment	nt required after 12 months (tick boxes where appropriate)
and		resc lospi	cribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.
	(and	C	The patient has primary myelofibrosis or post-polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis
		or	O A classification of risk of intermediate-2 or high-risk myelofibrosis according to either the International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or the Age-Adjusted DIPSS O A classification of risk of intermediate-1 myelofibrosis according to either the International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or the Age-Adjusted DIPSS
			and Patient has severe disease-related symptoms that are resistant, refractory or intolerant to available therapy
	and (C	A maximum dose of 20 mg twice daily is to be given
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)		nt required after 12 months	
	(and	С	The treatment remains appropriate and the patient is benefiting from treatment
	and (C	A maximum dose of 20 mg twice daily is to be given

I confirm that the above details are correct:

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Signed.	Date:	
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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Alectinib	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Patient has locally advanced, or metastatic, unresectable, nor and O There is documentation confirming that the patient has an AL and O Patient has an ECOG performance score of 0-2	n-small cell lung cancer K tyrosine kinase gene rearrangement using an appropriate ALK test
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O No evidence of progressive disease according to RECIST crit and The patient is benefitting from and tolerating treatment	eria

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PRESCRI	BER		PATIENT:
Name:			
Ward:			NHI:
Palboci	clib (Ibra	nce)
	sment		ired after 6 months oxes where appropriate)
	and	O I or	Patient has unresectable locally advanced or metastatic breast cancer There is documentation confirming disease is hormone-receptor positive and HER2-negative Patient has an ECOG performance score of 0-2 O Disease has relapsed or progressed during prior endocrine therapy O Patient is amenorrhoeic, either naturally or induced, with endocrine levels consistent with a postmenopausal or without menstrual-potential state O Patient has not received prior systemic treatment for metastatic disease
	and	0	Treatment must be used in combination with an endocrine partner Patient has not received prior funded treatment with a CDK4/6 inhibitor
or	and		Patient has an active Special Authority approval for ribociclib Patient has experienced a grade 3 or 4 adverse reaction to ribociclib that cannot be managed by dose reductions and requires treatment discontinuation Treatment must be used in combination with an endocrine partner There is no evidence of progressive disease since initiation of ribociclib
	sites (requ tick b	ired after 12 months oxes where appropriate) ment must be used in combination with an endocrine partner
and	d _		e is no evidence of progressive disease since initiation of palbociclib

I confirm that the above details are correct:	
Signed:	Date:

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PRES	CRIBER	PATIENT:	
Name	:		
Ward:		NHI:	
Mido	stauri	n en	
	ATION equisites	s (tick boxes where appropriate)	
	\bigcirc	Patient has a diagnosis of acute myeloid leukaemia	
Condition must be FMS tyrosine kinase 3 (FLT3) mutation positive		Condition must be FMS tyrosine kinase 3 (FLT3) mutation positive	
Patient must not have received a prior line of intensive chemotherapy for acute myeloid leukaemia			
	and	Patient is to receive standard intensive chemotherapy in combination with midostaurin only	
	and	Midostaurin to be funded for a maximum of 4 cycles	

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:	Name:		
Ward:	NHI:		
Ribociclib			
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Patient has unresectable locally advanced or metastatic and O There is documentation confirming disease is hormone-and			
Patient has an ECOG performance score of 0-2 and Disease has relapsed or progressed during prior or	endocrine therapy		
without menstrual-potential state and Patient has not received prior systemic end or	o in combination with an endocrine partner prior to 1 July 2024		
Treatment to be used in combination with an endocrine and Patient has not received prior funded treatment with a C			
Patient has an active Special Authority approval for palk and Patient has experienced a grade 3 or 4 adverse reaction requires treatment discontinuation and Treatment must be used in combination with an endocriand There is no evidence of progressive disease since initia	on to palbociclib that cannot be managed by dose reductions and ne partner		
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)			
Treatment must be used in combination with an endocrine parand There is no evidence of progressive disease since initiation of			

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Lenvatinib	
INITIATION – thyroid cancer Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Patient is currently on treatment with lenvatinib and met all refor The patient has locally advanced or metastatic different and O Patient must have symptomatic progressive disease or Patient must progressive disease at critical anatocannot be achieved by other measures and O A lesion without iodine uptake in a RAI scan Or Receiving cumulative RAI greater than or equal to or Experiencing disease progression after a RAI tree	tiated thyroid cancer ase prior to treatment pmical sites with a high risk of morbidity or mortality where local control o 600 mCi atment within 12 months treatments administered within 12 months of each other tely supressed
O Patient has an ECOG performance status of 0-2	
CONTINUATION – thyroid cancer Re-assessment required after 6 months Prerequisites (tick box where appropriate) There is no evidence of disease progression	

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Signed.	Date:	
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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:	Name:
Ward:	NHI:
Lenvatinib - continued	
INITIATION – unresectable hepatocellular carcinoma Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
Patient has unresectable hepatocellular carcinoma Patient has preserved liver function (Childs-Pugh A) and Transarterial chemoembolisation (TACE) is unsuitable and Patient has an ECOG performance status of 0-2 and Patient has not received prior systemic therapy for their Patient has experienced treatment-limiting toxicity and No disease progression since initiation of atezolizing	from treatment with atezolizumab with bevacizumab
CONTINUATION – unresectable hepatocellular carcinoma Re-assessment required after 6 months Prerequisites (tick box where appropriate) There is no evidence of disease progression INITIATION – renal cell carcinoma Re-assessment required after 4 months	
Prerequisites (tick boxes where appropriate)	
The patient has metastatic renal cell carcinoma and The disease is of predominant clear-cell histology and The patient has documented disease progression follow and The patient has an ECOG performance status of 0-2 and Lenvatinib is to be used in combination with everolimus	ring one previous line of treatment
Patient has received funded treatment with nivolumab for and Patient has experienced treatment limiting toxicity from the and Lenvatinib is to be used in combination with everolimus and There is no evidence of disease progression	or the second line treatment of metastatic renal cell carcinoma treatment with nivolumab
CONTINUATION – renal cell carcinoma Re-assessment required after 4 months Prerequisites (tick box where appropriate) There is no evidence of disease progression I confirm that the above details are correct:	

Signed: Date:

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:
ame: Name:	
/ard:NHI:NHI:	
Osimertinib	
INITIATION – NSCLC – first line Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	
Patient has locally advanced or metastatic, incurable, non-squ	amous non-small cell lung cancer (NSCLC)
Patient is treatment naïve	
O Patient has received prior treatment in the adjuvant setti	ng and/or while awaiting EGFR results
The patient has discontinued gefitinib or erlotinib o	due to intolerance
The cancer did not progress while on gefitinib or e	rlotinib
There is documentation confirming that the cancer expresses and	activating mutations of EGFR
Patient has an ECOG performance status 0-3	
Baseline measurement of overall tumour burden is documented	ed clinically and radiologically
Prerequisites (tick box where appropriate) Response to or stable disease with treatment in target lesions has b recent treatment period	een determined by comparable radiologic assessment following the most
INITIATION – NSCLC – second line Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	
O Patient has locally advanced or metastatic, incurable, non-squ	amous non-small cell lung cancer (NSCLC)
O Patient has an ECOG performance status 0-3 and	
The patient must have received previous treatment with erlotin and	ib or gefitinib
There is documentation confirming that the cancer expresses gefitinib	T790M mutation of EGFR following progression on or after erlotinib or
The treatment must be given as monotherapy	
O Baseline measurement of overall tumour burden is documented	d clinically and radiologically
CONTINUATION – NSCLC – second line Re-assessment required after 6 months Prerequisites (tick box where appropriate)	
Response to treatment in target lesions has been determined by conperiod	nparable radiologic assessment following the most recent treatment

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Axitinib	
INITIATION Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	
The patient has metastatic renal cell carcinoma and The disease is of predominant clear cell histology and The patient has documented disease progression following on and The patient has ECOG performance status of 0-2	e previous line of treatment
CONTINUATION Re-assessment required after 4 months Prerequisites (tick box where appropriate) O No evidence of disease progression.	

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Signed.	Date:	
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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Crizotinib	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Patient has locally advanced or metastatic, unresectable, non-and O There is documentation confirming that the patient has a ROS and O Patient has ECOG performance score of 0-3 and O Baseline measurement of overall tumour burden is documented.	rearrangement using an appropriate ROS1 test
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
Response to treatment has been determined by comparable rand No evidence of disease progression.	adiological assessment following the most recent treatment period

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Signed.	Date:	
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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:	Name:
Ward:	NHI:
Dasatinib	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a haematologist or any relevant with a protocol or guideline that has been endorsed by the Health National The patient has a diagnosis of chronic myeloid leukaemia (CM or O The patient has a diagnosis of Philadelphia chromosome-positor O The patient has a diagnosis of CML in chronic phase	ML) in blast crisis or accelerated phase
Patient has documented treatment failure* with im	with imatinib precluding further treatment with imatinib
with a protocol or guideline that has been endorsed by the Health Na	practitioner on the recommendation of a haematologist , or in accordance Z Hospital.
Lack of treatment failure while on dasatinib* and Dasatinib treatment remains appropriate and the patient is ber	nefiting from treatment
Note: *treatment failure for CML as defined by Leukaemia Net Guidelines.	

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Erlotinib	
INITIATION Re-assessment required after 4 months Prerequisites (tick boxes where appropriate) Patient has locally advanced or metastatic, unresectable, non and	
There is documentation confirming that the disease expresses and Patient is treatment naive Patient has received prior treatment in the adjuvant settion The patient has discontinued osimertinib or getiting and The cancer did not progress while on osimertinib	ing and/or while awaiting EGFR results hib due to intolerance
CONTINUATION Re-assessment required after 6 months Prerequisites (tick box where appropriate) O Radiological assessment (preferably including CT scan) indicates N	SCLC has not progressed

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I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Sunitinib	
INITIATION – RCC Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	
The patient has metastatic renal cell carcinoma The patient has not previously received funded sunitinib	
CONTINUATION – RCC Re-assessment required after 4 months Prerequisites (tick box where appropriate) No evidence of disease progression	
INITIATION – GIST Re-assessment required after 3 months Prerequisites (tick boxes where appropriate)	
The patient has unresectable or metastatic malignant gastrand The patient has unresectable or metastatic malignant gastrand The patient's disease has progressed following treatment or The patient has documented treatment-limiting intoless	ment with imatinib
CONTINUATION – GIST Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
The patient has responded to treatment or has stable diseast follows:	se as determined by Choi's modified CT response evaluation criteria as
or (HU) of 15% or more on CT and no new lesions and	n size of 10% or more or decrease in tumour density in Hounsfield Units no obvious progression of non-measurable disease) a the two above) and does not have progressive disease and no
The treatment remains appropriate and the patient is bene	iting from treatment
CONTINUATION – GIST pandemic circumstances Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
The patient has unresectable or metastatic malignant gasts and The patient is clinically benefiting from treatment and continand Sunitinib is to be discontinued at progression and The regular renewal requirements cannot be met due to Co	nued treatment remains appropriate

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HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:	Name:
Ward:	NHI:

Sunitinib - continued

Note: GIST - It is recommended that response to treatment be assessed using Choi's modified CT response evaluation criteria (J Clin Oncol, 2007, 25:1753-1759). Progressive disease is defined as either: an increase in tumour size of 10% or more and not meeting criteria of partial response (PR) by tumour density (HU) on CT; or: new lesions, or new intratumoral nodules, or increase in the size of the existing intratumoral nodules.

PRESCRIBER	PATIENT:	
Name:		
Ward:	NHI:	
Lapatinib		
INITIATION Prerequisites (tick box where appropriate) O For continuation use only		
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)		
and	cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology) any time point during the previous 12 months whilst on lapatinib	
Lapatinib not to be given in combina and Lapatinib to be discontinued at dise		

I confirm that the above details are correct:	
Signed:	Date:

PRESCRII	BER		PATIENT:
Name:			Name:
Ward:			NHI:
Pazopar	nib		
	sment		red after 3 months expected appropriate)
	and	0	The patient has metastatic renal cell carcinoma of predominantly clear cell histology
	and	or	O The patient is treatment naive
			The patient has only received prior cytokine treatment
	and		The patient has an ECOG performance score of 0-2
	•	The p	patient has intermediate or poor prognosis defined as:
		or	Lactate dehydrogenase level > 1.5 times upper limit of normal
		or	O Haemoglobin level < lower limit of normal
			O Corrected serum calcium level > 10 mg/dL (2.5 mmol/L)
		or	O Interval of < 1 year from original diagnosis to the start of systemic therapy
		or	C Karnofsky performance score of less than or equal to 70
		or	O 2 or more sites of organ metastasis
or			
		\circ	The patient has metastatic renal cell carcinoma
	and	\circ	The patient has discontinued sunitinib within 3 months of starting treatment due to intolerance
	and	\circ	The cancer did not progress whilst on sunitinib
	and	0	Pazopanib to be used for a maximum of 3 months
	sment	requii	red after 3 months ox where appropriate)
0	No evi	dence	e of disease progression

I confirm that the above details are correct:	
Signed:	Date:

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:	Name:
Ward:	NHI:
Gefitinib	
INITIATION Re-assessment required after 4 months Prerequisites (tick boxes where appropriate) O Patient has locally advanced, or metastatic, unresectable, non	a coulameura Non Small Call Lung Congar (NISCLC)
Patient has locally advanced, of metastatic, diffesectable, hold and Patient has received prior treatment in the adjuvant settion Patient has received prior treatment in the adjuvant settion The patient has discontinued osimertinib or erloting and The cancer did not progress whilst on osimertinib	ing and/or while awaiting EGFR results hib due to intolerance
There is documentation confirming that disease expresses act	tivating mutations of EGFR
CONTINUATION Re-assessment required after 6 months Prerequisites (tick box where appropriate) Radiological assessment (preferably including CT scan) indicates N	SCLC has not progressed

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PRES	CRIB	ER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Dexi	azox	ane)	
Prer	Э р	i tes Presc	(tick boxes where appropriate) ribed by, or recommended by a medical oncologist, paediatric ocol or guideline that has been endorsed by the Health NZ Ho	oncologist, haematologist or paediatric haematologist, or in accordance with ospital.
and	and (C		ven with curative intent dose of anthracycline will exceed 250mg/m2 doxorubicin equivalent or
	and (and	$\overline{}$	greater Dexrazoxane to be administered only whilst on anthracycline	treatment
		or	O Treatment to be used as a cardioprotectant for a child of	or young adult
			O Treatment to be used as a cardioprotectant for secondary	ary malignancy

May 2025

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:	Name:
Ward:	NHI:
Abiraterone acetate	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a medical oncologist, radiation been endorsed by the Health NZ Hospital.	oncologist or urologist, or in accordance with a protocol or guideline that has
Patient has prostate cancer and Patient has metastases and Patient's disease is castration resistant and	
Patient is symptomatic and Patient has disease progression (rising serum PS and Patient has ECOG performance score of 0-1 and Patient has not had prior treatment with taxane of Patient's disease has progressed following prior of and Patient has ECOG performance score of 0-2 and Patient has not had prior treatment with abiratero	chemotherapy containing a taxane
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a medical oncologist, radiation been endorsed by the Health NZ Hospital.	oncologist or urologist, or in accordance with a protocol or guideline that has
Significant decrease in serum PSA from baseline and No evidence of clinical disease progression	
No initiation of taxane chemotherapy with abiraterone and	
O The treatment remains appropriate and the patient is benefiting	ng from treatment

I confirm that the above details are correct: Signed: Date:

PRES	CRIBER	r	PATIENT:
Name	:		Name:
Ward:			NHI:
Abira	aterone	e acetate - continued	
Re-a	ssessme	ON – pandemic circumstances nt required after 6 months s (tick boxes where appropriate)	
	O	The patient is clinically benefiting from treatment and continue	d treatment remains appropriate
	and and	Abiraterone acetate to be discontinued at progression	
	O	No initiation of taxane chemotherapy with abiraterone	
	and	The regular renewal requirements cannot be met due to COVI	D-19 constraints on the health sector

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	e:		Name:
Ward	:		NHI:
Fulv	estrant		
Re-a	equisites	Patient has oestrogen-receptor positive locally advanced or m	an aromatase inhibitor or tamoxifen for their locally advanced or
Re-a	equisites	at required after 6 months (tick boxes where appropriate) cribed by, or recommended by a medical oncologist, or in accor	dance with a protocol or guideline that has been endorsed by the Health NZ
	and and	Treatment remains appropriate and patient is benefitting from Treatment to be given at a dose of 500 mg monthly No evidence of disease progression	treatment

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Signeg	 Date	

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Schedule. For community funding, see the Special Authority Criteria.				
PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Long-acting Somatostatin Analogues				
INITIATION – Malignant bowel obstruction Prerequisites (tick boxes where appropriate)				
The patient has nausea* and vomiting* due to malignant bow and Treatment with antiemetics, rehydration, antimuscarinic agen successful	rel obstruction* ts, corticosteroids and analgesics for at least 48 hours has not been			
O 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				
Or Treatment with surgery and radiotherapy is not suitable Or Treatment is for an interim period while awaiting the be				
Treatment with a dopamine agonist has been unsuccessful				
CONTINUATION – acromegaly Prerequisites (tick box where appropriate)				
O Without reassessment for applications where IGF1 levels have dec Note: In patients with acromegaly, treatment should be discontinued if IGF1 with radiotherapy treatment should be withdrawn every 2 years, for 1 month, biochemical evidence of remission (normal IGF1 levels) following treatment we	levels have no decreased 3 months after treatment. In patients treated for assessment of remission. Treatment should be stopped where there is			

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.

PRESCRI	RIBER PATI	ENT:				
Name:		e:				
Ward:	NHI:					
Long-ad	acting Somatostatin Analogues - continued					
	TION – Other indications uisites (tick boxes where appropriate)					
	O VIPomas and glucagonomas - for patients who are seriously ill in ord	der to improve their clinical state prior to definitive surgery				
or	Gastrinoma and					
	O Surgery has been unsuccessful or					
		antagonist or proton pump inhibitors has been unsuccessful				
or	O Insulinomas					
	O Surgery is contraindicated or has not been successful					
or or	O For pre-operative control of hypoglycaemia and for maintenance therapy					
	Carcinoid syndrome (diagnosed by tissue pathology and/or ur	inary 5HIAA analysis)				
	O Disabling symptoms not controlled by maximal medical therap	у				
Re-asses	TION – pre-operative acromegaly sessment required after 12 months quisites (tick boxes where appropriate)					
and	O Patient has acromegaly					
and	O Patient has a large pituitary tumour, greater than 10 mm at its wides					
	O Patient is scheduled to undergo pituitary surgery in the next six mon	ths				
Note: Th	Indications marked with * are unapproved indications The use of a long-acting somatostatin analogue in patients with fistulae, oeso under Special Authority	phageal varices, miscellaneous diarrhoea and hypotension will not be				

PRES	CRIBER		PATIENT:
Name	e:		Name:
Ward	:		NHI:
Amiı	nolevuli	nic acid hydrochloride	
		high grade malignant glioma (tick boxes where appropriate)	
	and and	Patient has newly diagnosed, untreated, glioblastoma multiforn	ne
		Treatment to be used as adjuvant to fluorescence-guided rese	ction
		Patient's tumour is amenable to complete resection	

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.

PRESCR	BER	PATIENT:
Name:		Name:
Ward:		NHI:
Tacrolir	nus	
	DN – organ transplant recipients sites (tick boxes where appropriate)	
or	O For use in organ transplant recipients O The individual is receiving induction therapy for an organ transplant recipients	nsplant
	ON – non-transplant indications* sites (tick boxes where appropriate) Prescribed by, or recommended by any specialist, or in accordance Hospital. O Patient requires long-term systemic immunosuppression	e with a protocol or guideline that has been endorsed by the Health NZ
an		ent because of unacceptable side effects or inadequate clinical response
Note: Ir	dications marked with * are unapproved indications	

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RS2062 - Etanercept

Arthritis - rheumatoid - INITIATION	311
Arthritis - rheumatoid - CONTINUATION	311
Adult-onset Still's disease - INITIATION	317
Adult-onset Still's disease - CONTINUATION	317
Ankylosing spondylitis - INITIATION	312
Ankylosing spondylitis - CONTINUATION	313
Oligoarticular course juvenile idiopathic arthritis - INITIATION	
Oligoarticular course juvenile idiopathic arthritis - CONTINUATION	310
Polyarticular course juvenile idiopathic arthritis - INITIATION	309
Polyarticular course juvenile idiopathic arthritis - CONTINUATION	309
Psoriatic arthritis - INITIATION	
Psoriatic arthritis - CONTINUATION	314
Pyoderma gangrenosum - INITIATION	316
Pyoderma gangrenosum - CONTINUATION	317
Severe chronic plaque psoriasis - CONTINUATION	316
Severe chronic plaque psoriasis, prior TNF use - INITIATION	
Severe chronic plague psoriasis, treatment-naive - INITIATION	315
Undifferentiated spondyloarthritis - INITIATION	318
Undifferentiated spondyloarthritis - CONTINUATION	318

May 2020

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	PRESCRIBER PATIENT:			
Name	e:			
Ward: NHI:				
Etan	erce	pt		
Re-a	ssess equis	sment requires (tick	articular course juvenile idiopathic arthritis quired after 6 months boxes where appropriate) d by, or recommended by a rheumatologist or named specialist, or in accordance with a protocol or guideline that has been endorsed alth NZ Hospital.	
		and	The patient has had an initial Special Authority approval for adalimumab for polyarticular course juvenile idiopathic arthritis (JIA)	
		0	The patient has experienced intolerable side effects from adalimumab The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for polyarticular course JIA	
	or	and o	O Moderate or high disease activity (cJADAS10 score of at least 2.5) after a 3-month trial of methotrexate (at the maximum tolerated dose)	
Re-a	ssess	ment req	polyarticular course juvenile idiopathic arthritis uired after 6 months boxes where appropriate)	
and			d by, or recommended by a rheumatologist or named specialist, or in accordance with a protocol or guideline that has been endorsed alth NZ Hospital.	
	and		atment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or lerance	
physician's global assessment from baseline			On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and	

I confirm that the above details are correct:

Signed: Date:

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	CRIB	BER	PATIENT:
Name	e:		
Ward:			NHI:
Etan	erce	pt - co	ontinued
Re-a	ssess equis	ment re ites (tic	poarticular course juvenile idiopathic arthritis equired after 6 months k boxes where appropriate) ed by, or recommended by a rheumatologist or named specialist, or in accordance with a protocol or guideline that has been endorsed ealth NZ Hospital.
		and	The patient has had an initial Special Authority approval for adalimumab for oligoarticular course juvenile idiopathic arthritis (JIA)
			The patient has experienced intolerable side effects from adalimumab The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for oligoarticular course JIA
	or		To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance Patient has had oligoarticular course JIA for 6 months duration or longer At least 2 active joints with limited range of motion, pain or tenderness after a 3-month trial of methotrexate (at the maximum tolerated dose) Moderate or high disease activity (cJADAS10 score greater than 1.5) with poor prognostic features after a 3-month trial of methotrexate (at the maximum tolerated dose) High disease activity (cJADAS10 score greater than 4) after a 6-month trial of methotrexate
Re-a	ssess equis F	iment re ites (tic Prescrib	- oligoarticular course juvenile idiopathic arthritis equired after 6 months k boxes where appropriate) ed by, or recommended by a rheumatologist or named specialist, or in accordance with a protocol or guideline that has been endorsed ealth NZ Hospital.
and	and	O su	ubsidised as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance
		or	Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baselinee On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRES	SCRIB	BER		PATIENT:	
Name	me: Name:				
Ward	ırd:NHI:				
Etan	erce	pt -	conti	nued	
Re-a	assess equis	ment ites (t	requi ick b ibed	is - rheumatoid red after 6 months oxes where appropriate) oy, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ	
and			0	The patient has had an initial Special Authority approval for adalimumab for rheumatoid arthritis	
		and		O The patient has experienced intolerable side effects	
			or	O The patient has received insufficient benefit to meet the renewal criteria for rheumatoid arthritis	
	or				
		and	0	Patient has had rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic citrullinated peptide (CCP) antibody positive) for six months duration or longer	
		and	0	Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance	
		and	0	Patient has tried and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated)	
		and	<u> </u>	Patient has tried and not responded to at least three months of methotrexate in combination with sulfasalazine and hydroxychloroquin sulphate at maximum tolerated doses (unless contraindicated)	
			or	O Patient has tried and not responded to at least three months of methotrexate in combination with the maximum tolerated dose of ciclosporin	
				O Patient has tried and not responded to at least three months of therapy at the maximum tolerated dose of leflunomide alone or in combination with methotrexate	
		and		O Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen joints	
			or	O Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip	
				elbow, kilee, alikie, and elitier shoulder of hip	
Re-a	assess	ment	requi	rthritis - rheumatoid red after 2 years expess where appropriate)	
		ibed	by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health		
and		O 1	Treati	ment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or rance	
	and		0	Following initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician	
		or	0	On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician	
	and	O 1	Etane	rcept to be administered at doses no greater than 50 mg every 7 days	

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.

ESCRIBER	PATIENT:
me:	Name:
rd:	NHI:
nercept - continued	
TIATION – ankylosing spondylitis -assessment required after 6 months erequisites (tick boxes where appropriate Prescribed by, or recommended by Hospital. The patient has had an and	y a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ n initial Special Authority approval for adalimumab for ankylosing spondylitis
or	experienced intolerable side effects from adalimumab received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for dylitis
and Patient has low back pand Patient has bilateral saland Patient's ankylosing spandrugs (NSAIDs), in conference regimen for a and	
or Bath Ankylosing 4 cm and lumba Patient has limit gender (see Not	ation of motion of the lumbar spine in the sagittal and the frontal planes as determined by the following Spondylitis Metrology Index (BASMI) measures: a modified Schober's test of less than or equal to r side flexion measurement of less than or equal to 10 cm (mean of left and right) ation of chest expansion by at least 2.5 cm below the average normal values corrected for age and es) dylitis Disease Activity Index (BASDAI) of at least 6 on a 0-10 scale
te: The BASDAI must have been determinated by the result of the result o	

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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	CRII	BER		PATIENT:	
Name):				
Ward:	·			NHI:	
Etan	erce	ept - d	conti	ued	
CON Re-a	TINU	JATION sment	I – a requ	kylosing spondylitis ed after 6 months xes where appropriate)	
(and		Prescri Hospita		y, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ	
	and	_ p		ing 12 weeks' initial treatment and for subsequent renewals, treatment has resulted in an improvement in BASDAI of 4 or more from pre-treatment baseline on a 10 point scale, or an improvement in BASDAI of 50%, whichever is less	
	and	O F	Phys	ian considers that the patient has benefited from treatment and that continued treatment is appropriate	
		O E	tane	cept to be administered at doses no greater than 50 mg every 7 days	
Re-a Prero	ssess equis	sment sites (t	requ ick b bed	c arthritis ed after 6 months xes where appropriate) y, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ	
and			$\overline{}$		
	The patient has had an initial Special Authority approval for adalimumab or secukinumab for psoriatic arthritis The patient has experienced intolerable side effects from adalimumab or secukinumab The patient has received insufficient benefit from adalimumab or secukinumab to meet the renewal criteria for adalimumab or secukinumab for psoriatic arthritis				
	or				\leq $ $
weekly or a maximum tolerated dose and Patient has tried and not responded to at least three months of sulfasalazine at a dose of at least 2 g per day a dose of up to 20 mg daily (or maximum tolerated doses) and		Patient has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg veekly or a maximum tolerated dose Patient has tried and not responded to at least three months of sulfasalazine at a dose of at least 2 g per day or leflunomide at			
				Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip	
		and	or or	Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application Patient has an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day	
				and has done so for more than three months	

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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	CRIE	BER			PATIENT:		
Name	e:				Name:		
Ward:	:				NHI:		
Etan	erce	pt ·	- conti	inued			
CONTINUATION – psoriatic arthritis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)							
and		Preso Hosp		by, or recommended by a rheumatologist, or in accordance	ce with a protocol or guideline that has been endorsed by the Health NZ		
		or	0	Following 3 to 4 months' initial treatment, the patient has clinically significant response to treatment in the opinion	s at least a 50% decrease in active joint count from baseline and a of the physician		
			0	The patient demonstrates at least a continuing 30% impresponse to prior etanercept treatment in the opinion of t	ovement in active joint count from baseline and a clinically significant he treating physician		
	and	0	Etan	ercept to be administered at doses no greater than 50 mg	every 7 days		
				e chronic plaque psoriasis, prior TNF use lired after 4 months			
Prer	equis	ites	(tick b	poxes where appropriate)			
and		Preso Hosp		by, or recommended by a dermatologist, or in accordance	with a protocol or guideline that has been endorsed by the Health NZ		
	and	O	The	patient has had an initial Special Authority approval for add	alimumab for severe chronic plaque psoriasis		
			0	The patient has experienced intolerable side effects from	adalimumab		
		or	0	The patient has received insufficient benefit from adalimulation plaque psoriasis	umab to meet the renewal criteria for adalimumab for severe chronic		
	and	0	Patie	ent must be reassessed for continuation after 3 doses			

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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.

RESCRIBER		PATIENT:		
ame:		Name:		
ard:		NHI:		
anercept	- continued			
e-assessmer	severe chronic plaque psoriasis, treatment-naive nt required after 4 months			
rerequisites -	(tick boxes where appropriate)			
O Pres Hosp nd		ce with a protocol or guideline that has been endorsed by the Health NZ		
or	O Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or place present for at least 6 months from the time of initial diagnosis			
and on the state of the state o	Patient has tried, but had an inadequate response (see Note) following (at maximum tolerated doses unless contraindicated A PASI assessment or Dermatology Quality of Life Index (DL	th a Dermatology Life Quality Index (DLQI) score greater than 10 to, or has experienced intolerable side effects from, at least three of the d): phototherapy, methotrexate, ciclosporin, or acitretin QI) assessment has been completed for at least the most recent prior preferably while still on treatment but no longer than 1 month following		
and	The most recent PASI or DLQI assessment is no more than 1	month old at the time of initiation		
hile still on trace, hand, foc evere, and fo	eatment but no longer than 1 month following cessation of the ot, genital or flexural areas at least 2 of the 3 PASI symptom si	laque psoriasis, a PASI score of greater than 10, as assessed preferably most recent prior treatment; for severe chronic plaque psoriasis of the ubscores for erythema, thickness and scaling are rated as severe or veryed is 30% or more of the face, palm of a hand or sole of a foot, as assessed tion of the most recent prior treatment.		

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:	Name:
Ward:	NHI:
Etanercept - continued	
CONTINUATION – severe chronic plaque psoriasis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
Patient had "whole body" severe chronic plaq	ue psoriasis at the start of treatment
Following each prior etanercept treatment more, or is sustained at this level, where Following each prior etanercept treatment for Following etanercept etalescept for Following etanercept etalescept etal	ent course the patient has a PASI score which is reduced by 75% or a compared with the pre-etanercept treatment baseline value ent course the patient has a Dermatology Quality of Life Index (DLQI) ared with the pre-treatment baseline value
or	
O Patient had severe chronic plaque psoriasis o	of the face, or palm of a hand or sole of a foot at the start of treatment
Following each prior etanercept treatment for all 3 of erythema, thickness and scattreatment course baseline values	ent course the patient has a reduction in the PASI symptom subscores aling, to slight or better, or sustained at this level, as compared to the
	ent course the patient has a reduction of 75% or more in the skin area ompared to the pre-etanercept treatment baseline value
or	
O Patient had severe chronic localised genital o	r flexural plaque psoriasis at the start of treatment
The patient has experienced a reductio compared to the pre-treatment baseline or	n of 75% or more in the skin area affected, or sustained at this level, as a value
O Patient has a Dermatology Quality of Li prior to commencing etanercept	fe Index (DLQI) improvement of 5 or more, as compared to baseline DLQI
and	
O Etanercept to be administered at doses no greater than 5	0 mg every 7 days
NUTATION 1	
INITIATION – pyoderma gangrenosum Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a dermatologist, or in accord Hospital.	dance with a protocol or guideline that has been endorsed by the Health NZ
Patient has pyoderma gangrenosum*	
Patient has received three months of conventional therap azathioprine, or methotrexate) and not received an adequ	y including a minimum of three pharmaceuticals (e.g. prednisone, ciclosporin, ate response
A maximum of 8 doses	
Note: Indications marked with * are unapproved indications.	

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Siurieu.	 Date.	

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	CRIB	ER			PATIENT:			
Name	:				Name:			
Ward:					NHI:			
Etan	erce	pt - ۵	onti	nued				
	iaiupe P	INUATION – pyoderma gangrenosum quisites (tick boxes where appropriate) Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. Patient has shown clinical improvement						
	and (and	\sim			tinues to require treatment of 8 doses			
Re-a	ssessi equisi P	ment i tes (t	equick b	red a	Still's disease ter 6 months where appropriate) recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ			
		and	or	0	The patient has had an initial Special Authority approval for etanercept for adult-onset Still's disease (AOSD) The patient has been started on tocilizumab for AOSD in a Health NZ Hospital The patient has experienced intolerable side effects from etanercept and/or tocilizumab The patient has received insufficient benefit from at least a three-month trial of adalimumab and/or tocilizumab such that they do not meet the renewal criteria for AOSD			
		and)))	Patie antii	Int diagnosed with AOSD according to the Yamaguchi criteria (J Rheumatol 1992;19:424-430) Int has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, non-steroidal flammatory drugs (NSAIDs) and methotrexate Int has persistent symptoms of disabling poorly controlled and active disease			
Re-a	CONTINUATION – adult-onset Still's disease Re-assessment required after 6 months Prerequisites (tick box where appropriate) Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and							
	У т	he pa	tient	has	sustained improvement in inflammatory markers and functional status			

I confirm that the above details are correct:

Signed: Date:

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	CRIB	ER		PATIENT:
lame	:			
Vard:				NHI:
tan	erce	pt	- conti	nued
Re-as	ssess	men	t requ	erentiated spondyloarthritis ired after 6 months oxes where appropriate)
(and	by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ			
	and	0		nt has undifferentiated peripheral spondyloarthritis* with active peripheral joint arthritis in at least four joints from the following: elbow, knee, ankle, and either shoulder or hip
	and	\circ		nt has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a mum tolerated dose
	and	\circ	Patie dose)	nt has tried and not responded to at least three months of sulfasalazine at a dose of at least 2 g per day (or maximum tolerated
	and	O	Patie	nt has tried and not responded to at least three months of leflunomide at a dose of up to 20 mg daily (or maximum tolerated dose)
		or	0	Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application
		or	0	Patient has an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour measured no more than one month prior to the date of this application
			0	ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months
Note:	Indic	catio	ns ma	rked with * are unapproved indications.
Re-as	ssess	men	t requ	ndifferentiated spondyloarthritis ired after 6 months oxes where appropriate)
		or	0	Applicant is a rheumatologist
			0	Applicant is a Practitioner and confirms that a rheumatologist has provided a letter, email or fax recommending that the patient continues with etanercept treatment
	and	or	0	Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician
			0	The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior etanercept treatment in the opinion of the treating physician
	and (0	Etane	ercept to be administered at doses no greater than 50 mg dose every 7 days

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:	Name:					
Ward:	NHI:					
Bevacizumab						
INITIATION – Recurrent Respiratory Papillomatosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)						
Prescribed by, or recommended by an otolaryngologist, or in a Hospital.	accordance with a protocol or guideline that has been endorsed by the Health NZ					
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) Prescribed by, or recommended by an otolaryngologist, or in a Hospital.	accordance with a protocol or guideline that has been endorsed by the Health NZ					
O Maximum of 6 doses and O The treatment is for intra-lesional administration and O There has been a reduction in surgical treatments or dis	ease regrowth as a result of treatment					
INITIATION – ocular conditions Prerequisites (tick boxes where appropriate)						
Ocular neovascularisation O Exudative ocular angiopathy						

Signed: Date:

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	SCRIB	BER	PATIENT:					
Name	ə:							
Ward	:		NHI:					
Ran	anibizumab							
Re-a	equis	ment ites (1 Prescr	Vet Age Related Macular Degeneration required after 3 months tick boxes where appropriate) ribed by, or recommended by an ophthalmologist or nurse practitioner, or in accordance with a protocol or guideline that has been sed by the Health NZ Hospital.					
		and	Wet age-related macular degeneration (wet AMD) Polypoidal choroidal vasculopathy Choroidal neovascular membrane from causes other than wet AMD					
		and	O The patient has developed severe endophthalmitis or severe posterior uveitis following treatment with bevacizumab or O There is worsening of vision or failure of retina to dry despite three intraocular injections of bevacizumab four weeks apart					
	or (and	O There is no structural damage to the central fovea of the treated eye					
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 ha								
and	e	$\overline{}$	sed by the Health NZ Hospital.					
	and	\bigcirc	Documented benefit must be demonstrated to continue Patient's vision is 6/36 or better on the Snellen visual acuity score					
	and	O -	There is no structural damage to the central fovea of the treated eye					

RS2065 - Infliximab

Crohn's disease (adults) - INITIATION	326
Crohn's disease (adults) - CONTINUATION	326
Crohn's disease (children) - INITIATION	326
Crohn's disease (children) - CONTINUATION	327
Graft vs host disease - INITIATION	322
Inflammatory bowel arthritis (axial) - INITIATION	
Inflammatory bowel arthritis (axial) - CONTINUATION	332
Inflammatory bowel arthritis (peripheral) - INITIATION	333
Inflammatory bowel arthritis (peripheral) - CONTINUATION	333
Pulmonary sarcoidosis - INITIATION	325
Acute fulminant ulcerative colitis - INITIATION	
Ankylosing spondylitis - INITIATION	322
Ankylosing spondylitis - CONTINUATION	323
Chronic ocular inflammation - INITIATION	325
Chronic ocular inflammation - CONTINUATION	325
Fistulising Crohn's disease - INITIATION	327
Fistulising Crohn's disease - CONTINUATION	327
Fulminant ulcerative colitis - CONTINUATION	
Neurosarcoidosis - INITIATION	
Neurosarcoidosis - CONTINUATION	
Plaque psoriasis - INITIATION	329
Plaque psoriasis - CONTINUATION	330
Psoriatic arthritis - INITIATION	
Psoriatic arthritis - CONTINUATION	323
Pyoderma gangrenosum - INITIATION	332
Pyoderma gangrenosum - CONTINUATION	332
Rheumatoid arthritis - INITIATION	
Rheumatoid arthritis - CONTINUATION	
Severe Behcet's disease - INITIATION	
Severe Behcet's disease - CONTINUATION	
Severe ocular inflammation - INITIATION	
Severe ocular inflammation - CONTINUATION	
Ulcerative colitis - INITIATION	
Ulcerative colitis - CONTINUATION	329

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

May 2025

PRES	CRI	BER		PATIENT:
Name	:			
Ward				NHI:
Inflix	ima	ab		
		sites	(tick b	ox host disease ox where appropriate) steroid-refractory acute graft vs. host disease of the gut
Re-a	sses	ssmen	t requ	atoid arthritis ired after 4 months oxes where appropriate)
and	Э —	Preso Hosp		by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
	and	\circ	The p	patient has had an initial Special Authority approval for adalimumab and/or etanercept for rheumatoid arthritis
		or	O O	The patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept Following at least a four month trial of adalimumab and/or etanercept, the patient did not meet the renewal criteria for adalimumab and/or etanercept
	and			ment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or rance
Re-a	sses	smen sites	t requ (tick b cribed	neumatoid arthritis ired after 6 months oxes where appropriate) by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
unu	and			ment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or rance
		or	0	Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician
			0	The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician
	and	O	Inflixi	mab to be administered at doses no greater than 3 mg/kg every 8 weeks
Re-a	sses	ssmen sites	t requ (tick b cribed	osing spondylitis ired after 3 months oxes where appropriate) by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
anu	and	O	The p	patient has had an initial Special Authority approval for adalimumab and/or etanercept for ankylosing spondylitis
		or	0	The patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept Following 12 weeks of adalimumab and/or etanercept treatment, the patient did not meet the renewal criteria for adalimumab and/or etanercept for ankylosing spondylitis

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	CRIE	BER			PATIENT:
Name	:				Name:
Ward:					NHI:
Inflix	ima	ıb -	contin	nued	
Re-a	ssess equis	Preso	t required tick to the cribed ital. Folloor by Physical controls and the cribed ital.		
INITI Re-a Prere	ce with a protocol or guideline that has been endorsed by the Health NZ alimumab and/or etanercept and/or secukinumab for psoriatic arthritis a reasonable trial of adalimumab and/or etanercept and/or secukinumab				
		or	0		and/or etanercept and/or secukinumab, the patient did not meet the
CONTINUATION – psoriatic arthritis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a rheumatologist, or in accordance Hospital. and					ce with a protocol or guideline that has been endorsed by the Health NZ
	and	or	O O Inflix	clinically significant response to treatment in the opinion	rovement in active joint count from baseline and a clinically significant the treating physician

Vard:nfliximab	- con	tinued	
nfliximab	- con	tinued	NHI:
	- seve		
NITIATION -			
	s (ticl	quired a	ar inflammation fter 4 months where appropriate)
	and) The	patient has had an initial Special Authority approval for adalimumab for severe ocular inflammation
		or	The patient has experienced intolerable side effects from adalimumab
		0	The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for severe ocular inflammation
or			
ε	and C) Patie	nt has severe, vision-threatening ocular inflammation requiring rapid control
		or	Treatment with high-dose steroids (intravenous methylprednisolone) followed by high dose oral steroids has proven ineffective at controlling symptoms
		\circ	Patient developed new inflammatory symptoms while receiving high dose steroids
		or O	Patient is aged under 8 years and treatment with high dose oral steroids and other immunosuppressants has proven ineffective at controlling symptoms
			3)
Re-assessme	ent re	quired a	ocular inflammation fter 12 months where appropriate)
C) _{Th}	e patien	t has had a good clinical response following 3 initial doses
or) Fo No	llowing e	each 12-month treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis ure (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of oid macular oedema)
or) Fo	llowing e	each 12-month treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to ily, or steroid drops less than twice daily if under 18 years old
Note: A trial vision loss if			ould be considered after every 24 months of stability, unless the patient is deemed to have extremely high risk of irreversible ithdrawn.

I confirm that the above details are correct:	
Signed:	Date:

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.

RESCRIBER	PATIENT:
ame:	Name:
ard:	NHI:
fliximab - continued	
NITIATION – chronic ocular inflammation e-assessment required after 4 months rerequisites (tick boxes where appropriate)	
O The patient has had an initi	ial Special Authority approval for adalimumab for chronic ocular inflammation
	prienced intolerable side effects from adalimumab
O The patient has recei ocular inflammation	ived insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for chronic
O Patient has severe uveitis u	uncontrolled with treatment of steroids and other immunosuppressants with a severe risk of vision
O Patient is 18 years or	older and treatment with at least two other immunomodulatory agents has proven ineffective ears and treatment with methotrexate has proven ineffective or is not tolerated at therapeutic dose
	ears and treatment with steroids or methotrexate has proven ineffective or is not tolerated at a disease requires control to prevent irreversible vision loss prior to achieving a therapeutic dose of
ONTINUATION – chronic ocular inflammation e-assessment required after 12 months erequisites (tick boxes where appropriate)	n
•	cal response following 3 initial doses
Nomenclature (SUN) criteria < ½ uveitic cystoid macular oedema)	ent period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis + anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of
	ent period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to steroid steroid steroid sparing effect, allowing reduction in prednisone to steroid steroi
ote: A trial withdrawal should be considered aft sion loss if infliximab is withdrawn.	ter every 24 months of stability, unless the patient is deemed to have extremely high risk of irreversible
IITIATION – Pulmonary sarcoidosis rerequisites (tick boxes where appropriate)	
O Patient has life-threatening pulmo	onary sarcoidosis that is refractory to other treatments

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

May 2025

PRES	SCRII	BER		PATIENT:
Name	e:			
Ward	:			NHI:
Inflix	cima	ıb -	contin	ued
Re-a	sses	smen	t requ	's disease (adults) ired after 6 months oxes where appropriate)
and			ribed ospita	by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health I.
	and	0	Patie	nt has active Crohn's disease
		or	0	Patient has a CDAI score of greater than or equal to 300, or HBI score of greater than or equal to 10
		or	\circ	Patient has extensive small intestine disease affecting more than 50 cm of the small intestine
		or	0	Patient has evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel resection
			0	Patient has an ileostomy or colostomy, and has intestinal inflammation
	and			nt has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators corticosteroids
1	equis	sites Preso	(tick b	ired after 2 years oxes where appropriate) by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health I.
		or	\bigcirc	CDAI score has reduced by 100 points from the CDAI score, or HBI score has reduced by 3 points, from when the patient was initiated on infliximab
		or	0	CDAI score is 150 or less, or HBI is 4 or less
			\cup	The patient has demonstrated an adequate response to treatment but CDAI score and/or HBI score cannot be assessed
	and	0	up to	mab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for 3 doses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen s after completing the last re-induction cycle
Re-a	sses	smen	t requ	's disease (children) ired after 6 months oxes where appropriate)
(C	Preso		by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
and	and	0	Paed	iatric patient has active Crohn's disease
		or	0	Patient has a PCDAI score of greater than or equal to 30
			\cup	Patient has extensive small intestine disease
	and	0		nt has tried but experienced an inadequate response to, or intolerable side effects from, prior therapy with immunomodulators corticosteroids

May 2025

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	CRII	BER		PATIENT:
Name:				
Ward:				NHI:
Inflix	ima	ab -	contin	ued
Re-as	sses qui:	smer sites Pres	t requ (tick t	Crohn's disease (children) uired after 2 years poxes where appropriate) by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health al.
	and	or or	up to	PCDAI score has reduced by 10 points from the PCDAI score when the patient was initiated on infliximab PCDAI score is 15 or less The patient has demonstrated an adequate response to treatment but PCDAI score cannot be assessed imab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for 3 doses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen as after completing the last re-induction cycle
Re-as	sses qui	smer sites Presi Hosp	t requestick to the control of the c	sing Crohn's disease uired after 6 months ooxes where appropriate) by, or recommended by a gastroenterologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ent has confirmed Crohn's disease Patient has one or more complex externally draining enterocutaneous fistula(e) Patient has one or more rectovaginal fistula(e)
Re-as	sses equi:	smer sites	t requ (tick t	istulising Crohn's disease priced after 2 years poxes where appropriate)
and			ospita	
	and	or O	up to	The number of open draining fistulae have decreased from baseline by at least 50% There has been a marked reduction in drainage of all fistula(e) from baseline (in the case of adult patients, as demonstrated by a reduction in the Fistula Assessment score), together with less induration and patient reported pain imab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for 3 doses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen as after completing the last re-induction cycle

I confirm that the above details are correct:

May 2025

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:		Name:
Ward:		NHI:
Infliximab - cont	inued	
Re-assessment rec	e fulminant ulcerative colitis quired after 6 weeks boxes where appropriate)	
O Prescribe Hospital.	d by, or recommended by a gastroenterologist, or in accord	lance with a protocol or guideline that has been endorsed by the Health NZ
and	ient has acute, fulminant ulcerative colitis atment with intravenous or high dose oral corticosteroids ha	as not been successful
Re-assessment rec Prerequisites (tick	boxes where appropriate) d by, or recommended by any relevant practitioner, or in ac	cordance with a protocol or guideline that has been endorsed by the Health
and Infli	ssessed every 6 months ximab to be administered at doses up to 5 mg/kg every 8 v	weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for nent for re-induction. Another re-induction may be considered sixteen
Prerequisites (tick	puired after 6 months boxes where appropriate) d by, or recommended by any relevant practitioner, or in ac	cordance with a protocol or guideline that has been endorsed by the Health
	ient has active ulcerative colitis	
or C	Patients SCCAI is greater than or equal to 4 Patients PUCAI score is greater than or equal to 20	
	ient has experienced an inadequate response to, or intoleratemic corticosteroids	able side effects from, prior therapy with immunomodulators and

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

May 2025

PRES	CRIE	BER		PATIENT:	
Name	e:				
Ward				NHI:	
Inflix	ima	b - c	ontin	ed .	
Re-a	ssess equis	sment sites (requ tick b	perative colitis ed after 2 years xes where appropriate)	
and		NZ Ho		y, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the	те неапп
		or	0	The SCCAI score has reduced by 2 points or more from the SCCAI score when the patient was initiated on infliximab	
			0	The PUCAI score has reduced by 30 points or more from the PUCAI score when the patient was initiated on infliximab	
	and	0	up to	ab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used doses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixter completing the last re-induction cycle	for een
Re-a	ssess siupe I	sment sites (requ tick b	psoriasis ed after 3 doses xes where appropriate) y, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health	ı NZ
		and	0	Patient has had an initial Special Authority approval for adalimumab, etanercept or secukinumab for severe chronic plaque soriasis	
			or	Patient has experienced intolerable side effects from adalimumab, etanercept or secukinumab	
				Patient has received insufficient benefit from adalimumab, etanercept or secukinumab to meet the renewal criteria for adalimumab, etanercept or secukinumab for severe chronic plaque psoriasis	r J
	or				
			or	Patient has "whole body" severe chronic plaque psoriasis with a Psoriasis Area and Severity Index (PASI) score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis	
			or	Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaque bave been present for at least 6 months from the time of initial diagnosis	ues
			U.	Patient has severe chronic localised genital or flexural plaque psoriasis where the plaques or lesions have been pres for at least 6 months from the time of initial diagnosis, and with a Dermatology Life Quality Index (DLQI) score greate than 10	
		and	0	Patient has tried, but had an inadequate response (see Note) to, or has experienced intolerable side effects from, at least to the following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, cyclosporin, or acitreting	
		and		A PASI assessment has been completed for at least the most recent prior treatment course (but preferably all prior treatment courses), preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course	ent
			O	The most recent PASI assessment is no more than 1 month old at the time of initiation	
while face, seve	still on the still of the still	on tre d, foot nd for	atmei , geni the fa	ponse" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 10, as assessed prefet but no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the or flexural areas at least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or explain of a hand or sole of a foot the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as as a treatment but no longer than 1 month following cessation of the most recent prior treatment.	he very

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:	Name:
Ward:	NHI:
Infliximab - co	ntinued
Re-assessment r	- plaque psoriasis equired after 3 doses ck boxes where appropriate)
or or	Patient had "whole body" severe chronic plaque psoriasis at the start of treatment Following each prior infliximab treatment course the patient has a PASI score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-infliximab treatment baseline value Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment Following each prior infliximab treatment course the patient has a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the treatment course baseline values Following each prior infliximab treatment course the patient has a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-infliximab treatment baseline value Patient had severe chronic localised genital or flexural plaque psoriasis at the start of treatment The patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline value Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing infliximab
Prerequisites (tid	equired after 18 months ck boxes where appropriate) bed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and O B and O P and	iopsy consistent with diagnosis of neurosarcoidosis atient has CNS involvement atient has steroid-refractory disease IV cyclophosphamide has been tried Treatment with IV cyclophosphamide is clinically inappropriate

I confirm that the above details are correct:

Signed: Date:

May 2025

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:	Name:
Ward:	NHI:
Infliximab - continued	
CONTINUATION – neurosarcoidosis Re-assessment required after 18 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a neurologist, or in accordance Hospital. and A withdrawal period has been tried and the patient has relapsor A withdrawal period has been considered but would not and There has been a marked reduction in prednisone dos and O There has been an improvement in MRI appeara	t be clinically appropriate
or Marked improvement in other symptomology	inces
treatment(s) appropriate for the particular symptom(s) The patient has severe gastrointestinal, rheumatologic two or more treatment appropriate for the particular synand The patient is experiencing significant loss of quality of life Note:	culitic symptoms and has not responded adequately to one or more (see Notes) and/or mucocutaneous symptoms and has not responded adequately to mptom(s) (see Notes)
 a) Behcet's disease diagnosed according to the International Study Group for measured using an appropriate quality of life scale such as that published b) Treatments appropriate for the particular symptoms are those that are contintravenous/oral steroids and other immunosuppressants for ocular symptoms; and colchicine, steroids and methotrexate for 	d in Gilworth et al J Rheumatol. 2004;31:931-7. Insidered standard conventional treatments for these symptoms, for example toms; azathioprine, steroids, thalidomide, interferon alpha and ciclosporin for
CONTINUATION – severe Behcet's disease Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Patient has had a good clinical response to initial treatment vand Infliximab to be administered at doses no greater than 5 mg/li	

I confirm that the above details are correct:

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

May 2025

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Infliximab - continued			
INITIATION – pyoderma gangrenosum Prerequisites (tick boxes where appropriate)			
Prescribed by, or recommended by a dermatologist, or in accordance Hospital.	e with a protocol or guideline that has been endorsed by the Health NZ		
Patient has pyoderma gangrenosum*			
azathioprine, or methotrexate) and not received an adequate r	uding a minimum of three pharmaceuticals (e.g. prednisone, ciclosporin, esponse		
A maximum of 8 doses			
Note: Indications marked with * are unapproved indications.			
CONTINUATION – pyoderma gangrenosum Prerequisites (tick boxes where appropriate)			
Prescribed by, or recommended by a dermatologist, or in accordance Hospital.	e with a protocol or guideline that has been endorsed by the Health NZ		
O Patient has shown clinical improvement			
Patient continues to require treatment			
A maximum of 8 doses			
INITIATION – Inflammatory bowel arthritis (axial) Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)			
O Patient has a diagnosis of active ulcerative colitis or active Cro	hn's disease		
Patient has had axial inflammatory pain for six months or more			
Patient is unable to take NSAIDs			
Patient has unequivocal sacroiliitis demonstrated by radiologic	al imaging or MRI		
by a physiotherapist	atment consisting of at least 3 months of an exercise regime supervised		
Patient has a BASDAl of at least 6 on a 0-10 scale completed pharmacological treatment	after the 3 month exercise trial, but prior to ceasing any previous		
CONTINUATION – Inflammatory bowel arthritis (axial) Re-assessment required after 2 years			
Prerequisites (tick box where appropriate)			
O Where treatment has resulted in an improvement in BASDAI of 4 or improvement in BASDAI of 50%, whichever is less	more points from pre-treatment baseline on a 10-point scale, or an		

SCRI	BER	PATIENT:			
e:					
l:		NHI:			
xima	ab -	continued			
		Inflammatory bowel arthritis (peripheral) at required after 6 months			
equi	sites	(tick boxes where appropriate)			
and	\circ	Patient has a diagnosis of active ulcerative colitis or active Crohn's disease			
	0	Patient has active arthritis in at least four joints from the following: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder, sternoclavicular			
	0	Patient has tried and not experienced a response to at least three months of methotrexate or azathioprine at a maximum tolerated dose (unless contraindicated)			
and		Patient has tried and not experienced a response to at least three months of sulfasalazine at a maximum tolerated dose (unless contraindicated)			
and		O Patient has a CRP level greater than 15 mg/L measured no more than one month prior to the date of this application			
	or	O Patient has an ESR greater than 25 mm per hour measured no more than one month prior to the date of this application			
		O ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months			
asses	ssmer	ON – Inflammatory bowel arthritis (peripheral) It required after 2 years (tick boxes where appropriate)			
٥٢	0	Following initial treatment, patient has experienced at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician			
or	0	Patient has experienced at least a continuing 30% improvement in active joint count from baseline in the opinion of the treating physician			
	itini	imab - IATION - I assessmen equisites and and or and or or ITINUATIC assessmen equisites			

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RS2067 - Tocilizumab

ı		
l	Rheumatoid Arthritis - INITIATION	337
I	Rheumatoid Arthritis - CONTINUATION	339
l	Rheumatoid Arthritis (patients previously treated with adalimumab or etanercept) - INITIATION	336
l	Adult-onset Still's disease - INITIATION	
l	Adult-onset Still's disease - CONTINUATION	340
l	Cytokine release syndrome - INITIATION	335
l	Idiopathic multicentric Castleman's disease - INITIATION	
l	Idiopathic multicentric Castleman's disease - CONTINUATION	
l	Moderate to severe COVID-19 - INITIATION	
l	Polyarticular juvenile idiopathic arthritis - INITIATION	338
l	Polyarticular juvenile idiopathic arthritis - CONTINUATION	
l	Previous use - INITIATION	335
l	Systemic juvenile idiopathic arthritis - INITIATION	
l	Systemic juvenile idiopathic arthritis - CONTINUATION	
ı	27-10-17-10-17-17-17-17-17-17-17-17-17-17-17-17-17-	

PRESCRIBER			PATIENT:
Name	e:		Name:
Ward	:		NHI:
Toci	lizur	mab	
Re-a	assess	sment requ	The patient has developed grade 3 or 4 cytokine release syndrome associated with the administration of blinatumomab for the treatment of acute lymphoblastic leukaemia
	or	and and	Tocilizumab is to be administered at doses no greater than 8 mg/kg IV for a maximum of 3 doses (if less than 30kg, maximum of 12 mg/kg) The patient is enrolled in the Malaghan Institute of Medical Research ENABLE trial programme The patient has developed CRS or Immune Effector Cell-Associated Neurotoxicity Syndrome (ICANS) following CAR T-Cell therapy for the treatment of relapsed or refractory B-cell non-Hodgkin lymphoma Tocilizumab is to be administered according to the consensus guidelines for CRS or ICANS for CAR T-cell therapy at doses no greater than 8 mg/kg IV for a maximum of 3 doses
Re-a	equis	sites (tick b	ired after 6 months poxes where appropriate) by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
and	and		Rheumatoid arthritis Systemic juvenile idiopathic arthritis Adult-onset Still's disease Polyarticular juvenile idiopathic arthritis Idiopathic multicentric Castleman's disease

I confirm that the above details are correct:	
Signed:	Date:

PRESCR	IBER		PATIENT:
Name:			
Ward:			NHI:
Tocilizu	ımab	- con	tinued
			natoid Arthritis (patients previously treated with adalimumab or etanercept) red after 6 months
Prerequ	isites	(tick b	oxes where appropriate)
O and			by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.
an	O d	The p	atient has had an initial Special Authority approval for adalimumab and/or etanercept for rheumatoid arthritis
		\circ	The patient has experienced intolerable side effects from adalimumab and/or etanercept
	or	0	The patient has received insufficient benefit from at least a three-month trial of adalimumab and/or etanercept such that they do not meet the renewal criteria for rheumatoid arthritis
an	d _		
	or	0	The patient is seronegative for both anti-cyclic citrullinated peptide (CCP) antibodies and rheumatoid factor
		an	The patient has been started on rituximab for rheumatoid arthritis in a Health NZ Hospital
			The patient has experienced intolerable side effects from rituximab At four months following the initial course of rituximab the patient has received insufficient benefit such that they do not meet the renewal criteria for rheumatoid arthritis

C:	D-1	
Signed.	Date:	
Oigilica.	 Daic.	

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	PRESCRIBER			PATIENT:
Name):			Name:
Ward	:			NHI:
Toci	lizum	nab	- cor	ntinued
Re-a	ssess equisi	ment	requ tick b	matoid Arthritis ired after 6 months poxes where appropriate)
and				by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.
	(nt has had severe and active erosive rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic linated peptide (CCP) antibody positive) for six months duration or longer
	and (and	C	Tocili	zumab is to be used as monotherapy
		or	0	Treatment with methotrexate is contraindicated
	and			Patient has tried and did not tolerate oral and/or parenteral methotrexate
	anu	or	0	Patient has tried and not responded to at least three months therapy at the maximum tolerated dose of ciclosporin alone or in combination with another agent
			\bigcirc	Patient has tried and not responded to at least three months therapy at the maximum tolerated dose of leflunomide alone or in combination with another agent
	and		\sim	
		or		Patient has persistent symptoms of poorly controlled and active disease in at least 20 active, swollen, tender joints Patient has persistent symptoms of poorly controlled and active disease in at least four active joints from the following: wrist,
				elbow, knee, ankle, and either shoulder or hip
Patient has a C-reactive protein level greater than 15 mg/L measured no more than application		0	Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application	
		or	0	C-reactive protein levels not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months
Re-a	ssess	ment	requ	nic juvenile idiopathic arthritis ired after 6 months oxes where appropriate)
(and				by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.
O Patient diagnosed with systemic juvenile idiopathic arthritis and			nt diagnosed with systemic juvenile idiopathic arthritis	
	(nt has tried and not responded to a reasonable trial of all of the following, either alone or in combination: oral or parenteral otrexate; non-steroidal anti-inflammatory drugs (NSAIDs); and systemic corticosteroids

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.

PRESCRI	BER		PATIENT:
Name:			Name:
Vard:			NHI:
ocilizu	mab ·	- con	ntinued
INITIATION Re-asses	ON – ac ssment sites (t	lult-d requi ick b	bonset Still's disease ired after 6 months oxes where appropriate) by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.
and			The patient has had an initial Special Authority approval for adalimumab and/or etanercept for adult-onset Still's disease (AOSD) The patient has been started on tocilizumab for AOSD in a Health NZ Hospital The patient has experienced intolerable side effects from adalimumab and/or etanercept The patient has received insufficient benefit from at least a three-month trial of adalimumab and/or etanercept such that they do not meet the renewal criteria for AOSD
Patient has tried and not responded to at least 6 months antiinflammatory drugs (NSAIDs) and methotrexate		OOO	Patient diagnosed with AOSD according to the Yamaguchi criteria (J Rheumatol 1992;19:424-430) Patient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, non-steroidal antiinflammatory drugs (NSAIDs) and methotrexate Patient has persistent symptoms of disabling poorly controlled and active disease
Re-asses	ssment sites (t	requick b	ticular juvenile idiopathic arthritis ired after 4 months oxes where appropriate) by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.
or	and and and	O O O O O O O O O O O O O O O O O O O	The patient has had an initial Special Authority approval for both etanercept and adalimumab for polyarticular course juvenile idiopathic arthritis (JIA) The patient has experienced intolerable side effects, or has received insufficient benefit from, both etanercept and adalimumab Treatment with a tumour necrosis factor alpha inhibitor is contraindicated Patient has had polyarticular course JIA for 6 months duration or longer To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance O At least 5 active joints and at least 3 joints with limited range of motion, pain or tenderness after a 3-month trial of methotrexate (at the maximum tolerated dose) O Moderate or high disease activity (cJADAS10 score of at least 2.5) after a 3-month trial of methotrexate (at the
		or	maximum tolerated dose) Color Low disease activity (cJADAS10 score between 1.1 and 2.5) after a 6-month trial of methotrexate

I confirm that the above details are correct:

May 2025

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:
Tocilizumab - continued	
or in accordance with a protocol Patient has severe HHV-8 and Treatment with an adequal and	
INITIATION – moderate to severe COVII Re-assessment required after 1 dose Prerequisites (tick boxes where appropria	
and Patient is receiving adjunct and Tocilizumab is to be admir	orobable) COVID-19 % on room air, or requiring supplemental oxygen t systemic corticosteroids, or systemic corticosteroids are contraindicated sistered at doses no greater than 8mg/kg IV for a maximum of one dose Iministered in combination with barcitinib
protocol or guideline that has be Following 6 months' initial significant response to tree On subsequent reapplicat	
protocol or guideline that has be Following up to 6 months' improvement criteria (ACF)	

I confirm that the above details are correct:

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:	Name:		
Ward:	NHI:		
Tocilizumab - continued			
CONTINUATION – adult-onset Still's disease Re-assessment required after 6 months Prerequisites (tick box where appropriate) Prescribed by, or recommended by a rheumatologist or Practitioner of the commended by the commended			
protocol or guideline that has been endorsed by the Health NZ Hosp and The patient has a sustained improvement in inflammatory markers a			
intolerance Following 3 to 4 months' initial treatment, the patient has physician's global assessment from baseline or	or monotherapy where use of methotrexate is limited by toxicity or s at least a 50% decrease in active joint count and an improvement in s at least a continuing 30% improvement in active joint count and		
CONTINUATION – idiopathic multicentric Castleman's disease Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a haematologist, rheumatologist or in accordance with a protocol or guideline that has been endorsed and The treatment remains appropriate and the patient has a sustained in			

PRES	SCRIE	ER		PATIENT:	
Name	e:			Name:	
Ward	:			NHI:	
Oma	lizuı	mab)		
Re-a	ssess equis	men ites Presc	severe asthma t required after 6 months (tick boxes where appropriate) cribed by, or recommended by a clinical immunologist or respirarsed by the Health NZ Hospital.	atory specialist, or in accordance with a protocol or guideline that has been	
	and	O O	Patient must be aged 6 years or older Patient has a diagnosis of severe asthma		
	and and and	0	Past or current evidence of atopy, documented by skin prick testing or RAST Total serum human immunoglobulin E (IgE) between 76 IU/mL and 1300 IU/ml at baseline Proven adherence with optimal inhaled therapy including high dose inhaled corticosteroid (budesonide 1,600 mcg per day or luticasone propionate 1,000 mcg per day or equivalent), plus long-acting beta-2 agonist therapy (at least salmeterol 50 mcg bd or eformoterol 12 mcg bd) for at least 12 months, unless contraindicated or not tolerated		
	unu	or	contraindicated or not tolerated	requivalent to at least 28 days treatment in the past 12 months, unless nic corticosteroids in the previous 12 months, where an exacerbation is for at least 3 days or parenteral steroids	
	and	0	Patient has an Asthma Control Test (ACT) score of 10 or less Baseline measurements of the patient's asthma control using application, and again at around 26 weeks after the first dose	the ACT and oral corticosteroid dose must be made at the time of to assess response to treatment	
Re-a	ssess equis	men ites	NN – severe asthma t required after 6 months (tick boxes where appropriate)		
and		NZ H	ospital.	ordance with a protocol or guideline that has been endorsed by the Health	
	and	0	An increase in the Asthma Control Test (ACT) score of at least A reduction in the maintenance oral corticosteroid dose or nun		

I confirm that the above details are correct:	
Signed:	Date:

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	RESCRIBER			PATIENT:
Name	me:			
Ward	ard:			NHI:
Oma	lizur	nab) - cc	ontinued
Re-a	ssess equis i	men ites Presc	t requ (tick b cribed	e chronic spontaneous urticaria uired after 6 months coxes where appropriate) by, or recommended by a clinical immunologist or dermatologist, or in accordance with a protocol or guideline that has been by the Health NZ Hospital.
	(and	O	Patie	ent must be aged 12 years or older
			ar	O Patient is symptomatic with Urticaria Activity Score 7 (UAS7) of 20 or above O Patient has a Dermatology life quality index (DLQI) of 10 or greater
	and			
	and	or	0	Patient has been taking high dose antihistamines (e.g. 4 times standard dose) and ciclosporin (> 3 mg/kg day) for at least 6 weeks Patient has been taking high dose antihistamines (e.g. 4 times standard dose) and at least 3 courses of systemic corticosteroids (> 20 mg prednisone per day for at least 5 days) in the previous 6 months Patient has developed significant adverse effects whilst on corticosteroids or ciclosporin
	anu	or	0	Treatment to be stopped if inadequate response* following 4 doses
			\cup	Complete response* to 6 doses of omalizumab
Re-a	ssess equis i	men ites Presc	t requ (tick t cribed	severe chronic spontaneous urticaria uired after 6 months boxes where appropriate) by, or recommended by a clinical immunologist or dermatologist, or in accordance with a protocol or guideline that has been by the Health NZ Hospital.
	or (0	Patie	ent has previously had a complete response* to 6 doses of omalizumab
		and		Patient has previously had a complete response* to 6 doses of omalizumab Patient has relapsed after cessation of omalizumab therapy
of les	ss thar	n 4 f and	rom b	esponse defined as less than 50% reduction in baseline UAS7 and DLQI score, or an increase in Urticaria Control Test (UCT) score paseline. Patient is to be reassessed for response after 4 doses of omalizumab. Complete response is defined as UAS7 less than or less than or equal to 5; or UCT of 16. Relapse of chronic urticaria on stopping prednisone/ciclosporin does not justify the funding of

I confirm that the above details are correct:

Cianad.	Data.	
Signeg	 Date	

PRE	SCRIBER	PATIENT:		
Nam	e:	Name:		
Ward	:	NHI:		
Siltu	ıximab			
Re-a	IATION assessment required after 6 months requisites (tick boxes where appropriate) Prescribed by, or recommended by a haematologist or rheumatologist the Health NZ Hospital. Patient has severe HHV-8 negative idiopathic multicentric Casand Treatment with an adequate trial of corticosteroids has proven and Siltuximab is to be administered at doses no greater than 11 negative idiopathic multicentric Casand	ineffective		
Re-a	ATINUATION assessment required after 12 months requisites (tick box where appropriate)			
and	Prescribed by, or recommended by a haematologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. The treatment remains appropriate and the patient has sustained improvement in inflammatory markers and functional status			

I confirm that the above details are correct:	
Signed:	Date:

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Obinutuzumab	
INITIATION Re-assessment requipers (tick by Prescribed Hospital.) The pand The pand The pand The pand Patient and Patient and Obining 6 cyc.	by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ patient has progressive Binet stage A, B or C CD20+ chronic lymphocytic leukaemia requiring treatment patient is obinutuzumab treatment naive patient is not eligible for full dose FCR due to comorbidities with a score > 6 on the Cumulative Illness Rating Scale (CIRS) or sed renal function (creatinine clearance < 70mL/min) In that adequate neutrophil and platelet counts* unless the cytopenias are a consequence of marrow infiltration by CLL in that good performance status Unusumab to be administered at a maximum cumulative dose of 8,000 mg and in combination with chlorambucil for a maximum of
symptoms a higher E * greater than or equa INITIATION – follicu Re-assessment requi	the patient. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL disease COG (2 or 3) is acceptable where treatment with obinutuzumab is expected to improve symptoms and improve ECOG score to < 2. al to 1.5 × 10 ⁹ /L and platelets greater than or equal to 75 × 10 ⁹ /L Iar / marginal zone lymphoma ired after 9 months oxes where appropriate)
and Paties and Paties and	Patient has follicular lymphoma Patient has marginal zone lymphoma In tis refractory to or has relapsed within 12 months of a rituximab containing combined chemo-immunotherapy regimen* In thas an ECOG performance status of 0-2 In that been previously treated with no more than four chemotherapy regimens Intuzumab to be administered at a maximum dose of 1000 mg for a maximum of 6 cycles in combination with chemotherapy*
CONTINUATION – fc Re-assessment requi Prerequisites (tick b	bilicular / marginal zone lymphoma ired after 24 months oxes where appropriate) In that no evidence of disease progression following obinutuzumab induction therapy
and	utuzumab to be administered at a maximum of 1000 mg every 2 months for a maximum of 2 years utuzumab to be discontinued at disease progression

May 2025

PRESCRIBER		PATIENT:				
Name:	ne:					
Ward:	/ard:NHI:					
Pertuzumab						
	O Patient has not received prior treatment for their metasta	tic disease and has had a treatment free interval of at least 12 months				
and on an analysis of an analysi	between prior (neo)adjuvant chemotherapy treatment and The patient has good performance status (ECOG grade 0-1) Pertuzumab to be administered in combination with trastuzumate Pertuzumab maximum first dose of 840 mg, followed by maximum Pertuzumab to be discontinued at disease progression	ab				
	O The patient has metastatic breast cancer expressing HE O The cancer has not progressed at any time point during O Patient has previously discontinued treatment with pertudisease progression O Patient has signs of disease progression	R-2 IHC 3+ or ISH+ (including FISH or other current technology) the previous 12 months whilst on pertuzumab and trastuzumab zumab and trastuzumab for reasons other than severe toxicity or vith pertuzumab and trastuzumab				

I confirm that the above details are correct:	
Signed:	Date:

May 2025

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

PRESCRIBER	PATIENT:
Name:	
Ward:	NHI:
Cetuximab	
	ond neck cancer, locally advanced oxes where appropriate)
and	nt has locally advanced, non-metastatic, squamous cell cancer of the head and neck
and Patier	nt has an ECOG performance score of 0-2
O To be	administered in combination with radiation therapy
Prerequisites (tick be and There and Patier	ctal cancer, metastatic red after 6 months oxes where appropriate) In thas metastatic colorectal cancer located on the left side of the colon (see Note) In this is documentation confirming disease is RAS and BRAF wild-type In that an ECOG performance score of 0-2 In that not received prior funded treatment with cetuximab Cetuximab is to be used in combination with chemotherapy
u O	Chemotherapy is determined to not be in the best interest of the patient based on clinician assessment
Prerequisites (tick be No evidence	plorectal cancer, metastatic red after 6 months ox where appropriate) e of disease progression rectal cancer comprises of the distal one-third of the transverse colon, the splenic flexure, the descending colon, the sigmoid colon,

I confirm that the above details are correct: Signed: Date:

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PRE	SCRIE	BER		PATIENT:
Nam	e:			
Ward	l:			NHI:
Aflik	erce	ept		
Re-a	assess requis	sment sites (t Prescr	requ ick b ibed	ge Related Macular Degeneration ired after 3 months oxes where appropriate) by, or recommended by an ophthalmologist or nurse practitioner, or in accordance with a protocol or guideline that has been y the Health NZ Hospital.
	or	and and or		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 There is no structural damage to the central fovea of the treated eye Patient has not previously been treated with ranibizumab for longer than 3 months Patient has current approval to use ranibizumab for treatment of wAMD and was found to be intolerant to ranibizumab within 3 months Patient has previously* (*before June 2018) received treatment with ranibizumab for wAMD and disease was stable while on treatment
Re-a	assess requis	sment sites (t	requick bibed sed b	Vet Age Related Macular Degeneration irred after 12 months oxes where appropriate) by, or recommended by an ophthalmologist or nurse practitioner, or in accordance with a protocol or guideline that has been y the Health NZ Hospital. mented benefit must be demonstrated to continue nt's vision is 6/36 or better on the Snellen visual acuity score e is no structural damage to the central fovea of the treated eye

PRESCRIBER		PATIENT:			
Name:	e:				
Ward:		NHI:			
Aflibercept -	continued				
Re-assessment Prerequisites (t Prescri	iabetic Macular Oedema required after 4 months tick boxes where appropriate) ibed by, or recommended by an ophthalmologist or nurse praced by the Health NZ Hospital.	ctitioner, or in accordance with a protocol or guideline that has been			
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					
Re-assessment Prerequisites (t Prescriendors and and and and and and and and	There is stability or two lines of Snellen visual acuity gain There is structural improvement on OCT scan (with reduction in Patient's vision is 6/36 or better on the Snellen visual acuity so There is no centre-involving sub-retinal fibrosis or foveal atrople				

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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	ne:				Name:
Ward	:				NHI:
Secu	ıkin	uma	b		
Re-a	sses	smen	t requ	e chronic plaque psoriasis, second-line biologic ired after 4 months oxes where appropriate)	
and		Preso Hosp		by, or recommended by a dermatologist, or in accordance	e with a protocol or guideline that has been endorsed by the Health NZ
	and		The I	patient has had an initial Special Authority approval for ad bital, for severe chronic plaque psoriasis	alimumab or etanercept, or has trialled infliximab in a Health NZ
		or	0	The patient has experienced intolerable side effects from	n adalimumab, etanercept or infliximab
			\bigcirc	The patient has received insufficient benefit from adalim	umab, etanercept or infliximab
A Psoriasis Area and Severity Index (PASI) assessment or Dermatology Quality of Life Index for at least the most recent prior treatment course, preferably while still on treatment but no lo each prior treatment course				least the most recent prior treatment course, preferably v	
	and	0	The	most recent PASI or DQLI assessment is no more than 1	month old at the time of application
Re-a	ssess equis	smen sites	t requ (tick b cribed	severe chronic plaque psoriasis, second-line biologic ired after 6 months poxes where appropriate) by, or recommended by a dermatologist, or in accordance	e with a protocol or guideline that has been endorsed by the Health NZ
and					
		or	0	Patient's PASI score has reduced by 75% or more (PASI	75) as compared to baseline PASI prior to commencing secukinumab
			0	Patient has a Dermatology Quality of Life Index (DLQI) is commencing secukinumab	mprovement of 5 or more, as compared to baseline DLQI prior to
	and	0	Secu	kinumab to be administered at a maximum dose of 300 m	ng monthly

I confirm that the above details are correct:

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	CRIB	ER		PATIENT:
Name	e:			
Ward:	:			NHI:
Secu	ıkinu	ıma	b - c	rontinued
Re-a	ssessi equisi	ment ites (requ tick b	e chronic plaque psoriasis, first-line biologic ired after 4 months oxes where appropriate) by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and		lospi		by, or recommended by a definition of the accordance with a process of galacinic trial rice book shoulded by the recall rive
		or	0	Patient has "whole body" severe chronic plaque psoriasis with a Psoriasis Area and Severity Index (PASI) score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis
		or	0	Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis
			0	Patient has severe chronic localised genital or flexural plaque psoriasis where the plaques or lesions have been present for at least 6 months from the time of initial diagnosis, and with a Dermatology Life Quality Index (DLQI) score greater than 10
	and (C	Patie follow	nt has tried, but had an inadequate response (see Note) to, or has experienced intolerable side effects from, at least three of the ving (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, ciclosporin, or acitretin
	and	\sim	treatr	SI assessment or Dermatology Quality of Life Index (DLQI) assessment has been completed for at least the most recent prior ment course, preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course
	(most recent PASI or DQLI assessment is no more than 1 month old at the time of application
psori recer for er more	asis, ant prion rythem of the	a PAS r trea na, th e face	SI sco atmen aickne e, pala	burse is defined as a minimum of 12 weeks of treatment. "Inadequate response" is defined as: for whole body severe chronic plaque or of greater than 10, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most t; for severe chronic plaque psoriasis of the face, hand, foot, genital or flexural areas, at least 2 of the 3 PASI symptom sub scores and scaling are rated as severe or very severe, and for the face, palm of a hand or sole of a foot the skin area affected is 30% or m of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month following cessation of the atment.
Re-a	ssessi	ment	requ	evere chronic plaque psoriasis, first-line biologic ired after 6 months oxes where appropriate)
			or	Patient's PASI score has reduced by 75% or more (PASI 75) as compared to baseline PASI prior to commencing secukinumab
				O Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing secukinumab
		or	an	O Patient had severe chronic localised genital or flexural plaque psoriasis at the start of treatment
				O The patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline value
				O Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing secukinumab
	and (C	Secu	kinumab to be administered at a maximum dose of 300 mg monthly

I confirm that the above details are correct:

PRES	CRIE	BER			PATIENT:
Name	e:				Name:
Ward	:				NHI:
Secu	ıkin	uma	b - c	continued	
				osing spondylitis, second-line biologic ired after 3 months	
				oxes where appropriate)	
(and		Presc Hospi		by, or recommended by a rheumatologist, or in accordance	ce with a protocol or guideline that has been endorsed by the Health NZ
	and		The p	patient has had an initial Special Authority approval for ad	alimumab and/or etanercept for ankylosing spondylitis
		or	0	The patient has experienced intolerable side effects from	n a reasonable trial of adalimumab and/or etanercept
			0	Following 12 weeks of adalimumab and/or etanercept treand/or etanercept for ankylosing spondylitis	eatment, the patient did not meet the renewal criteria for adalimumab
Re-a	ssess	sment	requ	inkylosing spondylitis, second-line biologic ired after 6 months oxes where appropriate)	
and		Presc Hospi		by, or recommended by a rheumatologist, or in accordance	ce with a protocol or guideline that has been endorsed by the Health NZ
unu	and			wing 12 weeks initial treatment of secukinumab treatment line on a 10 point scale, or by 50%, whichever is less	t, BASDAI has improved by 4 or more points from pre-secukinumab
	and	\circ	Phys	ician considers that the patient has benefitted from treatm	nent and that continued treatment is appropriate
			Secu	kinumab to be administered at doses no greater than 300	mg monthly

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Zigneg.	i jate:	
Oigilica.	 Duic.	

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER				PATIENT:	PATIENT:	
Name	ə:					
Ward	:			NHI:		
Seci	ukinı	umal) - c	tinued		
Re-a	equis	ment ites (1	requ tick b	e arthritis d after 6 months es where appropriate) g, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ		
and		Hospit				
		and	0	atient has had an initial Special Authority approval for adalimumab, etanercept or infliximab for psoriatic arthritis		
			or	Patient has experienced intolerable side effects from adalimumab, etanercept or infliximab		
				Patient has received insufficient benefit from adalimumab, etanercept or infliximab to meet the renewal criteria for adalimumab, etanercept or infliximab for psoriatic arthritis		
	or					
		and	\circ	atient has had severe active psoriatic arthritis for six months duration or longer		
		_	0	atient has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg eekly or a maximum tolerated dose		
		and	0	atient has tried and not responded to at least three months of sulfasalazine at a dose of at least 2 g per day or leflunomide at dose of up to 20 mg daily (or maximum tolerated doses)		
			or	Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen, tender joints		
				Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip		
		and			١H	
			or	Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application		
			or	Patient has an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour		
				ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months		
Re-a	assess	ment	requ	d after 6 months es where appropriate)		
Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endo Hospital.		, or recommended by a rneumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ				
		or	0	ollowing 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a inically significant response to treatment in the opinion of the physician		
			0	he patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant esponse to prior secukinumab treatment in the opinion of the treating physician		
	and	O :	Secu	numab to be administered at doses no greater than 300 mg monthly		
					_	

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.

Name:	
INITIATION – early breast cancer Prerequisites (tick boxes where appropriate) Patient has early breast cancer expressing HER2 IHC3+ or ISH+ and Documentation of pathological invasive residual disease in the breast and/or axiliary lymph nodes following completion of surgery and Patient has completed systemic neoadjuvant therapy with trastuzumab and chemotherapy prior to surgery and Patient has left ventricular ejection fraction of 45% or greater and Adjuvant treatment with trastuzumab emtansine to be commenced within 12 weeks of surgery and Trastuzumab emtansine to be discontinued at disease progression Total adjuvant treatment duration must not exceed 42 weeks (14 cycles) INITIATION – metastatic breast cancer Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology) and Patient has previously received trastuzumab and chemotherapy, separately or in combination and Patient has received prior therapy for metastatic disease* or The patient has received prior therapy for metastatic diseases* Patient has a good performance status (ECOG 0-1) and Patient has a good performance status (ECOG 0-1) and Patient has a good performance status (ECOG 0-1) and Patient has a good performance status (ECOG 0-1)	
INITIATION – early breast cancer Prerequisites (tick boxes where appropriate) Patient has early breast cancer expressing HER2 IHC3+ or ISH+ and Documentation of pathological invasive residual disease in the breast and/or axiliary lymph nodes following completion of surger and Disease has not progressed during neoadjuvant therapy with trastuzumab and chemotherapy prior to surgery Disease has not progressed during neoadjuvant therapy and Adjuvant treatment with trastuzumab emtansine to be commenced within 12 weeks of surgery Adjuvant treatment with trastuzumab emtansine to be commenced within 12 weeks of surgery Trastuzumab emtansine to be discontinued at disease progression and Total adjuvant treatment duration must not exceed 42 weeks (14 cycles) INITIATION – metastatic breast cancer Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology) and Patient has previously received trastuzumab and chemotherapy, separately or in combination The patient has received prior therapy for metastatic disease* The patient has received prior therapy for metastatic disease Patient has a good performance status (ECOG 0-1) Patient has a good performance status (ECOG 0-1) Patient has a good performance status (ECOG 0-1) Patient has a good performance status (ECOG 0-1)	
Prerequisites (tick boxes where appropriate) Patient has early breast cancer expressing HER2 IHC3+ or ISH+ and Documentation of pathological invasive residual disease in the breast and/or axiliary lymph nodes following completion of surger and Patient has completed systemic neoadjuvant therapy with trastuzumab and chemotherapy prior to surgery and Disease has not progressed during neoadjuvant therapy and Patient has left ventricular ejection fraction of 45% or greater and Adjuvant treatment with trastuzumab emtansine to be commenced within 12 weeks of surgery and Trastuzumab emtansine to be discontinued at disease progression and Total adjuvant treatment duration must not exceed 42 weeks (14 cycles) INITIATION – metastatic breast cancer Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology) and Patient has previously received trastuzumab and chemotherapy, separately or in combination The patient has received prior therapy for metastatic disease* The patient has a good performance status (ECOG 0-1) and Patient has a good performance status (ECOG 0-1) Patient has a good performance status (ECOG 0-1) Patient has early bread trastus (ECOG 0-1) Patient has a good performance status (ECOG 0-1)	
Documentation of pathological invasive residual disease in the breast and/or axiliary lymph nodes following completion of surgery and Patient has completed systemic neoadjuvant therapy with trastuzumab and chemotherapy prior to surgery and Patient has left ventricular ejection fraction of 45% or greater and Adjuvant treatment with trastuzumab emtansine to be commenced within 12 weeks of surgery and Trastuzumab emtansine to be discontinued at disease progression Total adjuvant treatment duration must not exceed 42 weeks (14 cycles) INITIATION – metastatic breast cancer Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology) and Patient has previously received trastuzumab and chemotherapy, separately or in combination The patient has received prior therapy for metastatic disease* The patient has a good performance status (ECOG 0-1) Patient does not have symptomatic brain metastases	
Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology) and O Patient has previously received trastuzumab and chemotherapy, separately or in combination and O The patient has received prior therapy for metastatic disease* or O The patient developed disease recurrence during, or within six months of completing adjuvant therapy* and O Patient has a good performance status (ECOG 0-1) and O Patient does not have symptomatic brain metastases or	,
Patient has previously received trastuzumab and chemotherapy, separately or in combination On The patient has received prior therapy for metastatic disease* On The patient developed disease recurrence during, or within six months of completing adjuvant therapy* and Patient has a good performance status (ECOG 0-1) On Patient does not have symptomatic brain metastases On Patient does not have symptomatic brain metastases	
The patient has received prior therapy for metastatic disease* The patient developed disease recurrence during, or within six months of completing adjuvant therapy* The patient developed disease recurrence during, or within six months of completing adjuvant therapy* Patient has a good performance status (ECOG 0-1) Patient does not have symptomatic brain metastases Or	
Patient has a good performance status (ECOG 0-1) O Patient does not have symptomatic brain metastases or	
or	
O Patient has not received prior funded trastuzumab emtansine or trastuzumab deruxtecan treatment O Patient has discontinued trastuzumab deruxtecan due to intolerance and O The cancer did not progress while on trastuzumab deruxtecan	
and O Treatment to be discontinued at disease progression	

I confirm that the above details are correct:

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:	Name:			
Ward:	NHI:			
Trastuzumab emtansine - continued				
CONTINUATION – metastatic breast cancer Re-assessment required after 6 months				
Prerequisites (tick boxes where appropriate)				
The cancer has not progressed at any time point during the previous approval period whilst on trastuzumab emtansine				
Treatment to be discontinued at disease progression				
Note: *Note: Prior or adjuvant therapy includes anthracycline, other chemoth	erapy, biological drugs, or endocrine therapy.			

RS1973 - Rituximab

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364	
Steroid dependent nephrotic syndrome (SDNS) or frequently relapsing nephrotic syndrome (FRNS) - CON	NTINUATION
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Steroid resistant nephrotic syndrome (SRNS) - INITIATION	364
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Aggressive CD20 positive NHL - CONTINUATION	
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Merro exterior possibilities of the second control of the second c	363
Warm autoimmune haemolytic anaemia (warm AIHA) - INITIATION	360
Warm autoimmune haemolytic anaemia (warm AIHA) - CONTINUATION	360

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Rituximab (Riximyo)		
INITIATION – haemophilia with inhibitors Prerequisites (tick boxes where appropriate)		
	ce with a protocol or guideline that has been endorsed by the Health NZ	
O Patient has mild congenital haemophilia complicated by inhibi	tors	
O Patient has severe congenital haemophilia complicated by inh	ibitors and has failed immune tolerance therapy	
O Patient has acquired haemophilia		
CONTINUATION – haemophilia with inhibitors Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a haematologist, or in accordance Hospital.	ce with a protocol or guideline that has been endorsed by the Health NZ	
Patient was previously treated with rituximab for haemophilia vand An initial response lasting at least 12 months was demonstrate and Patient now requires repeat treatment		
INITIATION – post-transplant Prerequisites (tick boxes where appropriate)		
The patient has B-cell post-transplant lymphoproliferative discount of the used for a maximum of 8 treatment cycles	rder*	
Note: Indications marked with * are unapproved indications.		
CONTINUATION – post-transplant Prerequisites (tick boxes where appropriate)		
The patient has had a rituximab treatment-free interval of 12 r		
The patient has B-cell post-transplant lymphoproliferative disc	rder*	
O To be used for no more than 6 treatment cycles Note: Indications marked with * are unapproved indications.		

I confirm that the above details are correct:	
Signed:	Date:

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	CRIB	BER		PATIENT:	
Name	:			Name:	
Ward:				NHI:	
Ritux	tima	b (Rixim)	yo) - continued		
Re-as	ssess	ment requ	ent, low-grade lymphomas or hairy cell leukaemia* uired after 9 months boxes where appropriate)		
		and O	The patient has indolent low grade NHL or hairy cell leuk To be used for a maximum of 6 treatment cycles	kaemia* with relapsed disease following prior chemotherapy	
	or	The patient has indolent, low grade lymphoma or hairy cell leukaemia* requiring first-line systemic chemotherapy and To be used for a maximum of 6 treatment cycles			
			-grade lymphomas' includes follicular, mantle, marginal zon Il leukaemia' also includes hairy cell leukaemia variant.	ne and lymphoplasmacytic/Waldenstrom macroglobulinaemia. *Unapproved	
Re-as	ssess	ment requ	indolent, low-grade lymphomas or hairy cell leukaemia uired after 12 months boxes where appropriate)	a*	
	and (and	O The	patient has had a rituximab treatment-free interval of 12 m patient has indolent, low-grade NHL or hairy cell leukaem e used for no more than 6 treatment cycles		
			-grade lymphomas' includes follicular, mantle, marginal zo Il leukaemia' also includes hairy cell leukaemia variant.	ne and lymphoplasmacytic/Waldenstrom macroglobulinaemia. *Unapproved	
			essive CD20 positive NHL boxes where appropriate)		
		and on and	The patient has treatment naive aggressive CD20 position. To be used with a multi-agent chemotherapy regimen give. To be used for a maximum of 8 treatment cycles.		
	or	and	The patient has aggressive CD20 positive NHL with relation to be used for a maximum of 6 treatment cycles	psed disease following prior chemotherapy	
Note:	'Agg	gressive C	D20 positive NHL' includes large B-cell lymphoma and Bu	rkitt's lymphoma/leukaemia.	

I confirm that the above details are correct:

Signed: Date:

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:	Name:		
Ward:	NHI:		
Rituximab (Riximyo) - continued			
CONTINUATION – aggressive CD20 positive NHL Prerequisites (tick boxes where appropriate)			
The patient has had a rituximab treatment-free interval or and The patient has relapsed refractory/aggressive CD20 post and To be used with a multi-agent chemotherapy regimen give and To be used for a maximum of 4 treatment cycles	sitive NHL ven with curative intent		
Note: 'Aggressive CD20 positive NHL' includes large B-cell lymphoma and Burkitt's lymphoma/leukaemia. INITIATION – Chronic lymphocytic leukaemia Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)			
O The patient has progressive Binet stage A, B or C chroni and	ic lymphocytic leukaemia (CLL) requiring treatment		
O The patient is rituximab treatment naive			
and	lowing no more than three prior lines of chemotherapy treatment Interval of 12 months or more if previously treated with fludarabine and		
O The patient's disease has relapsed within 36 month with funded venetoclax	hs of previous treatment and rituximab treatment is to be used in combination		
The patient has good performance status			
or Rituximab treatment is to be used in combination v	on CLL with funded venetoclax for relapsed/refractory chronic lymphocytic leukaemia		
and Rituximab to be administered in combination with fludarabine and cyclophosphamide, bendamustine or venetoclax for a many 6 treatment cycles and It is planned that the patient receives full dose fludarabine and cyclophosphamide (orally or dose equivalent intravenous administered in combination with fludarabine and cyclophosphamide, bendamustine or venetoclax for a many 6 treatment cycles			
bendamustine or venetoclax Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma. A line of chemotherapy treatment is considered to compristandard therapeutic chemotherapy regimen and supportive treatments. 'Good performance status' means ECOG score of 0-1, however, in patemporarily debilitated by their CLL disease symptoms a higher ECOG (2 or 3) is acceptable where treatment with rituximab is expected to important symptoms and improve ECOG score to < 2.			

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Rituximab (Riximyo) - continued	
CONTINUATION – Chronic lymphocytic leukaemia Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
The patient's disease has relapsed within 36 months of portain with funded venetoclax	previous treatment and rituximab treatment is to be used in combination
The patient's disease has relapsed following no m	nore than one prior line of treatment with rituximab for CLL
	ore since commencement of initial rituximab treatment
The patient does not have chromosome 17p delet	ion CLL
O It is planned that the patient receives full dose flud administration) or bendamustin	darabine and cyclophosphamide (orally or dose equivalent intravenous
Rituximab to be administered in combination with fludarabine a 6 treatment cycles	and cyclophosphamide, bendamustine or venetoclax for a maximum of
Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymp standard therapeutic chemotherapy regimen and supportive treatments.	phoma. A line of chemotherapy treatment is considered to comprise a known
Hospital. Patient has cold haemagglutinin disease* and Patient has severe disease which is characterized by symptom symptoms and	natic anaemia, transfusion dependence or disabling circulatory t of 375 mg/m2 of body surface area per week for a total of 4 weeks
CONTINUATION – severe cold haemagglutinin disease (CHAD) Re-assessment required after 8 weeks	
Prerequisites (tick boxes where appropriate)	
Hospital.	ee with a protocol or guideline that has been endorsed by the Health NZ ekly for 4 weeks) have proven ineffective and treatment with higher
Patient was previously treated with rituximab for severe and An initial response lasting at least 12 months was demonand Patient now requires repeat treatment	
Note: Indications marked with * are unapproved indications.	

May 2025

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:	
Ritu	ximab	(Riximy	ro) - continued	
Re-a	ssessm	ent requ	autoimmune haemolytic anaemia (warm AIHA) uired after 8 weeks boxes where appropriate)	
and		escribed spital.	by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ	
	and) One > 5 r	of the following treatments has been ineffective: steroids (including if patient requires ongoing steroids at doses equivalent to mg prednisone daily), cytotoxic agents (e.g. cyclophosphamide monotherapy or in combination), intravenous immunoglobulin total rituximab dose used would not exceed the equivalent of 375 mg/m2 of body surface area per week for a total of 4 weeks	
Note	: Indica	tions ma	arked with * are unapproved indications.	
CONTINUATION – warm autoimmune haemolytic anaemia (warm AIHA) Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate)			uired after 8 weeks	
and		escribed spital.	by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ	
	or		rious treatment with lower doses of rituximab (100 mg weekly for 4 weeks) have proven ineffective and treatment with higher es (375 mg/m² weekly for 4 weeks) is now planned	
		and	Patient was previously treated with rituximab for warm autoimmune haemolytic anaemia*	
		and	An initial response lasting at least 12 months was demonstrated	
		0	Patient now requires repeat treatment	
Note	: Indica	tions ma	arked with * are unapproved indications.	
Re-a	INITIATION – immune thrombocytopenic purpura (ITP) Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ			
and	Ho	spital.		
		or O	Patient has immune thrombocytopenic purpura* with a platelet count of less than or equal to 20,000 platelets per microlitre	
		0	Patient has immune thrombocytopenic purpura* with a platelet count of 20,000 to 30,000 platelets per microlitre and significant mucocutaneous bleeding	
	and	0	Treatment with steroids and splenectomy have been ineffective	
	or	or O	Treatment with steroids has been ineffective and splenectomy is an absolute contraindication	
		or O	Other treatments including steroids have been ineffective and patient is being prepared for elective surgery (e.g. splenectomy)	
	and) The	total rituximab dose used would not exceed the equivalent of 375 mg/m2 of body surface area per week for a total of 4 weeks	
Note	Note: Indications marked with * are unapproved indications.			
I confi	rm that	the abov	ve details are correct:	

May 2025

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	CRII	BER PATIENT:		
Name	:	Name:		
Ward:		NHI:		
Ritux	ima	ab (Riximyo) - continued		
CONTINUATION – immune thrombocytopenic purpura (ITP) Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate)				
and	Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed Hospital. Ind			
	or	O Previous treatment with lower doses of rituximab (100 mg weekly for 4 weeks) have proven ineffective and treatment with higher doses (375 mg/m² weekly for 4 weeks) is now planned		
		O Patient was previously treated with rituximab for immune thrombocytopenic purpura*		
		An initial response lasting at least 12 months was demonstrated and Patient now requires repeat treatment		
Note:	Ind	ications marked with * are unapproved indications.		
and	and	sment required after 8 weeks sites (tick boxes where appropriate) Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. The total rituximab dose used would not exceed the equivalent of 375 mg/m2 of body surface area per week for a total of 4 weeks Patient has thrombotic thrombocytopenic purpura* and has experienced progression of clinical symptoms or persistent thrombocytopenia despite plasma exchange Patient has acute idiopathic thrombotic thrombocytopenic purpura* with neurological or cardiovascular pathology ications marked with * are unapproved indications.		
		JATION – thrombotic thrombocytopenic purpura (TTP)		
		sment required after 8 weeks sites (tick boxes where appropriate)		
and		Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
	and			
	and	O Patient now requires repeat treatment		
Note:	Note: Indications marked with * are unapproved indications.			
		· · · · · · · · · · · · · · · · · · ·		

I confirm that the above details are correct:

Signed: Date:

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Rituximab (Riximyo) - continued			
INITIATION – pure red cell aplasia (PRCA) Re-assessment required after 6 weeks Prerequisites (tick box where appropriate) Prescribed by, or recommended by a haematologist, or in accordance Hospital. and Patient has autoimmune pure red cell aplasia* associated with a der Note: Indications marked with * are unapproved indications.	ce with a protocol or guideline that has been endorsed by the Health NZ monstrable B-cell lymphoproliferative disorder		
CONTINUATION – pure red cell aplasia (PRCA) Re-assessment required after 6 weeks Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Patient was previously treated with rituximab for pure red cell aplasia* associated with a demonstrable B-cell lymphoproliferative disorder and demonstrated an initial response lasting at least 12 months Note: Indications marked with * are unapproved indications.			
or disease after at least 3 months	clophosphamide has failed to achieve significant improvement of nosphamide > 15 g or a further repeat 3 month induction course of 15 g		
CONTINUATION – ANCA associated vasculitis			
Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate) Patient has been diagnosed with ANCA associated vasculitis* and Patient has previously responded to treatment with rituximab band The total rituximab dose would not exceed the equivalent of 37			
Note: Indications marked with * are unapproved indications.			

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:	Name:		
Ward:	NHI:		
Rituximab (Riximyo) - continued			
INITIATION – treatment refractory systemic lupus erythematosus (SLE) Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a rheumatologist or nephrologist the Health NZ Hospital. and The patient has severe, immediately life- or organ-threatening and The disease has proved refractory to treatment with steroids a and	at a dose of at least 1 mg/kg 6 months with maximal tolerated doses of azathioprine, mycophenolate		
Note: Indications marked with * are unapproved indications.			
CONTINUATION – treatment refractory systemic lupus erythematosus (SLE) Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a rheumatologist or nephrologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. Patient's SLE* achieved at least a partial response to the previous round of prior rituximab treatment and The disease has subsequently relapsed and Maximum of two 1000 mg infusions of rituximab Note: Indications marked with * are unapproved indications.			
INITIATION – Antibody-mediated organ transplant rejection Prerequisites (tick box where appropriate) O Patient has been diagnosed with antibody-mediated organ transplant rejection* Note: Indications marked with * are unapproved indications.			
INITIATION – ABO-incompatible organ transplant Prerequisites (tick box where appropriate) O Patient is to undergo an ABO-incompatible solid organ transplant* Note: Indications marked with * are unapproved indications.			

I confirm that the above details are correct:

Signed: Date:

May 2025

I confirm that the above details are correct:

Signed: Date:

PRES	CRIBER PATIENT:			
Name				
Ward:				
Ritux	kimab (Riximyo) - continued			
Re-as	INITIATION – Steroid dependent nephrotic syndrome (SDNS) or frequently relapsing nephrotic syndrome (FRNS) Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate)			
and	Prescribed by, or recommended by a nephrologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
	Patient is a child with SDNS* or FRNS* and			
	Treatment with steroids for at least a period of 3 months has been ineffective or associated with evidence of steroid toxicity and			
	O Treatment with ciclosporin for at least a period of 3 months has been ineffective and/or discontinued due to unacceptable side effects and			
	O Treatment with mycophenolate for at least a period of 3 months with no reduction in disease relapses and			
	The total rituximab dose used would not exceed the equivalent of 375 mg/m² of body surface area per week for a total of 4 weeks			
Note:	Indications marked with a * are unapproved indications.			
Prere	TINUATION – Steroid dependent nephrotic syndrome (SDNS) or frequently relapsing nephrotic syndrome (FRNS) sessment required after 8 weeks equisites (tick boxes where appropriate) Prescribed by, or recommended by a nephrologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. Patient who was previously treated with rituximab for nephrotic syndrome* and Treatment with rituximab was previously successful and has demonstrated sustained response for > 6 months, but the condition has relapsed and the patient now requires repeat treatment The total rituximab dose used would not exceed the equivalent of 375 mg/m² of body surface area per week for a total of 4 weeks Indications marked with a * are unapproved indications.			
INITIATION – Steroid resistant nephrotic syndrome (SRNS) Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a nephrologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
and	Patient is a child with SRNS* where treatment with steroids and ciclosporin for at least 3 months have been ineffective Treatment with tacrolimus for at least 3 months has been ineffective and Genetic causes of nephrotic syndrome have been excluded and The total rituximab dose used would not exceed the equivalent of 375 mg/m² of body surface area per week for a total of 4 weeks			
Note:	Indications marked with a * are unapproved indications.			

PRESCRIBER	PATIENT:				
Name:	Name:				
Ward:	NHI:				
Rituximab (Riximyo) - continued					
CONTINUATION – Steroid resistant nephrotic syndrome (SRNS) Re-assessment required after 8 weeks					
Prerequisites (tick boxes where appropriate)					
Prescribed by, or recommended by a nephrologist, or in accordar Hospital.	nce with a protocol or guideline that has been endorsed by the Health NZ				
Patient who was previously treated with rituximab for nephr	O Patient who was previously treated with rituximab for nephrotic syndrome*				
Treatment with rituximab was previously successful and ha condition has relapsed and the patient now requires repeat and	s demonstrated sustained response for greater than 6 months, but the treatment				
	lent of 375 mg/m ² of body surface area per week for a total of 4 weeks				
Note: Indications marked with a * are unapproved indications.					
weekly for four weeks	of 1,000 mg rituximab administered fortnightly, or 4 doses of 375 mg/m2 administere				
The patient has experienced a severe episode or atta supportive of a severe attack of NMOSD) or	ack of NMOSD (rapidly progressing symptoms and clinical investigations				
The patient has experienced a breakthrough at and	tack of NMOSD				
O The patient is receiving treatment with mycoph	enolate				
The patients is receiving treatment with corticosteroids					
CONTINUATION – Neuromyelitis Optica Spectrum Disorder (NMOSD) Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)					
weekly for four weeks	of 1,000 mg rituximab administered fortnightly, or 4 doses of 375 mg/m2 administere				
The patients has responded to the most recent course of ri	tuximab				
The patient has not received rituximab in the previous 6 mo	onths				

I confirm that the above details are correct:	
Signed:	Date:

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Rituximab (Riximyo) - continued			
Hospital. One of the following dose regimens is to be used: 375 mg/m.	with a protocol or guideline that has been endorsed by the Health NZ 2 of body surface area per week for a total of four weeks, or 500 mg once		
or ineffective Or Treatment with at least one other immunosuppres	nmunosuppressant for at least a period of 12 months has been		
CONTINUATION – Severe Refractory Myasthenia Gravis Re-assessment required after 2 years Prerequisites (tick boxes where appropriate) Or Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. Or One of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg of the following dose regimens are total of four weeks.			
weekly for four weeks, or two 1,000 mg doses given two weel and An initial response lasting at least 12 months was demonstrated and	ted		
or least 12 months The patient's myasthenia gravis has relapsed des least 12 months	steroids and at least one other immunosuppressant for a period of at spite treatment with at least one immunosuppressant for a period of at months and have been discontinued due to unacceptable side effects		
INITIATION – Severe antisynthetase syndrome			
Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)			
Patient has confirmed antisynthetase syndrome O Patient has severe, immediately life or organ threatening disease, including interstitial lung disease and O Treatment with at least 3 immunosuppressants (oral steroids, cyclophosphamide, methotrexate, mycophenolate, ciclos azathioprine) has not be effective at controlling active disease			
Rapid treatment is required due to life threatening compand Maximum of four 1,000 mg infusions of rituximab	plications		

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:		
Name:			
Ward:	NHI:		
Rituximab (F	Riximyo) - continued		
Re-assessmer	DN – Severe antisynthetase syndrome at required after 12 months (tick boxes where appropriate)		
and and	Patient's disease has responded to the previous rituximab treatment with demonstrated improvement in inflammatory markers, muscle strength and pulmonary function The patient has not received rituximab in the previous 6 months Maximum of two cycles of 2 × 1,000 mg infusions of rituximab given two weeks apart		
	graft versus host disease (tick boxes where appropriate)		
and	Patient has refractory graft versus host disease following transplant Treatment with at least 3 immunosuppressants (oral steroids, ciclosporin, tacrolimus, mycophenolate, sirolimus) has not be effective at controlling active disease		
and	The total rituximab dose used would not exceed the equivalent of 375 mg/m² of body surface area per week for a total of 4 weeks		
and	Patient has severe chronic inflammatory demyelinating polyneuropathy (CIPD) Treatment with steroids and intravenous immunoglobulin and/or plasma exchange has not been effective at controlling active disease At least one other immunosuppressant (cyclophosphamide, ciclosporin, tacrolimus, mycophenolate) has not been effective at controlling active disease		
and	One of the following does regime to be used: 975 mg/m2 of body out for a total of four weeks on 500 mg and		
	One of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg once weekly for four weeks, or two 1,000 mg doses given two weeks apart		
CONTINUATION – severe chronic inflammatory demyelinating polyneuropathy Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)			
and	Patient's disease has responded to the previous rituximab treatment with demonstrated improvement in neurological function compared to baseline		
and	The patient has not received rituximab in the previous 6 months		
	One of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg once weekly for four weeks, or two 1,000 mg doses given two weeks apart		

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:	Name:		
Ward:	NHI:		
Rituximab (Riximyo) - continued			
Hospital. Patient has severe anti-NMDA receptor a and Treatment with steroids and active disease	ist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ		
or One of the following dose regimens is to weekly for four weeks, or two 1,000 mg of the following dose regimens is to weekly for four weeks, or two 1,000 mg of the following dose regimens is to weekly for four weeks, or two 1,000 mg of the following dose regimens is to weekly for four weeks, or two 1,000 mg of the following dose regimens is to weekly for four weeks, or two 1,000 mg of the following dose regimens is to weekly for four weeks, or two 1,000 mg of the following dose regimens is to weekly for four weeks, or two 1,000 mg of the following dose regimens is to weekly for four weeks, or two 1,000 mg of the following dose regimens is to weekly for four weeks, or two 1,000 mg of the following dose regimens is to weekly for four weeks, or two 1,000 mg of the following dose regimens is to weekly for four weeks, or two 1,000 mg of the following dose regimens is to weekly for four weeks, or two 1,000 mg of the following dose regimens is to weekly for four weeks, or two 1,000 mg of the following dose regimens is to weekly for four weeks, or two 1,000 mg of the following dose regimens is to weekly for four weeks, or two 1,000 mg of the following dose regimens is the following dose regimens the following dose regim	life threatening complications be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg once		
Hospital. Patient's disease has responded to the pand The patient has not received rituximab in and The patient has experienced a relapse a and	ist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ previous rituximab treatment with demonstrated improvement in neurological function the previous 6 months and now requires further treatment be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg once		
INITIATION – CD20+ low grade or follicular B-cell NHL Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)			
or On To be used for a maximum of 6 tre	or follicular B-cell NHL requiring first-line systemic chemotherapy		

I confirm that the above details are correct:

Signed: Date:

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PRESCRIBER		PATIENT:	
Name:		Name:	
Ward:		NHI:	
Rituximab (Rixir	myo) - continued		
CONTINUATION - Re-assessment re	- CD20+ low grade or follicular B-cell NHL equired after 24 months k boxes where appropriate)		
and Pa	emotherapy	ow grade or follicular B-cell NHL following induction with first-line systemic etherapy for 2 years at a dose of 375 mg/m2 every 8 weeks (maximum of	
Re-assessment re	mbranous nephropathy equired after 6 weeks k boxes where appropriate)		
or	Patient has biopsy-proven primary/idiopathic n Patient has PLA2 antibodies with no evidence	membranous nephropathy* of secondary cause, and an eGFR of > 60ml/min/1.73m2	
and	easures (see Note)	age kidney disease despite more than 3 months of treatment with conservative valent of 375mg/m2 of body surface area per week for a total of 4 weeks	
Re-assessment re	- Membranous nephropathy equired after 6 weeks k boxes where appropriate)		
O Pa	atient was previously treated with rituximab for mer	mbranous nephropathy*	
or	Treatment with rituximab was previously succe treatment	essful, but the condition has relapsed, and the patient now requires repeat	
	Patient achieved partial response to treatment	t and requires repeat treatment (see Note)	
and Th	ne total rituximab dose used would not exceed the	equivalent of 375 mg/m2 of body surface area per week for a total of 4 weeks	
Note:			
	rked with * are unapproved indications.	- Foldon and training	
 b) High risk of progression to end-stage kidney disease defined as > 5g/day proteinuria. c) Conservative measures include renin-angiotensin system blockade, blood-pressure management, dietary sodium and protein restriction, treatment of 			
dyslipidaemia, and anticoagulation agents unless contraindicated or the patient has experienced intolerable side effects.			
d) Partial response defined as a reduction of proteinuria of at least 50% from baseline, and between 0.3 grams and 3.5 grams per 24 hours.			

I confirm that the above details are correct:

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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:	Name:		
Ward:	NHI:		
Rituximab (Riximyo) - continued			
INITIATION – B-cell acute lymphoblastic leukaemia/lymphoma*			
Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)			
O Patient has newly diagnosed B-cell acute lymphoblastic leukaemia/lymphoma* and O Treatment must be in combination with an intensive chemotherapy protocol with curative intent			
The total rituximab dose would not exceed the equivalent of 3	375 mg/m2 per dose for a maximum of 18 doses		
Note: Indications marked with * are unapproved indications.			
INITIATION – desensitisation prior to transplant Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate)			
O Patient requires desensitisation prior to mismatched allogenic stem cell transplant* O Patient would receive no more than two doses at 375 mg/m2 of body-surface area Note: Indications marked with * are unapproved indications.			
INITIATION – pemiphigus* Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a dermatologist or relevant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
Patient has severe rapidly progressive pemphigus and Is used in combination with systemic corticosteroids (2 and			
or Skin involvement is at least 5% body surface are OSignificant mucosal involvement (10 or more mucosal involvement) Involvement of two or more mucosal sites	a cosal erosions) or diffuse gingivitis or confluent large erosions		
Patient has pemphigus and Patient has not experienced adequate clinical benefit from systemic corticosteroids (20 mg/day) in combination with a steroid sparing agent, unless contraindicated			
			Note: Indications marked with * are unapproved indications.

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Rituximab (Riximyo) - continued	
CONTINUATION – pemiphigus* Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
	cialist, or in accordance with a protocol or guideline that has been endorsed
Patient has experienced adequate clinical benefit from rituxim ulceration and reduction in corticosteroid requirement and	ab treatment, with improvement in symptoms and healing of skin
Patient has not received rituximab in the previous 6 months Note: Indications marked with * are unapproved indications.	
INITIATION – immunoglobulin G4-related disease (IgG4-RD*) Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate)	
O Patient has confirmed diagnosis of IgG4-RD*	
or lowering corticosteroid dose below 5 mg per day (predn	g anti-rheumatic drugs for at least 3 months has been ineffective in isone equivalent) without relapse g anti-rheumatic drugs is contraindicated or associated with evidence of
Total rituximab dose used should not exceed a maximum of tw	wo 1000 mg infusions of rituximab given two weeks apart
Note: Indications marked with * are unapproved indications.	
CONTINUATION – immunoglobulin G4-related disease (IgG4-RD*) Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
Treatment with rituximab for IgG4-RD* was previously s but the condition has relapsed Patient is receiving maintenance treatment for IgG4-RD	uccessful and patient's disease has demonstrated sustained response,
and O Rituximab re-treatment not to be given within 6 months of pre- and O Maximum of two 1000 mg infusions of rituximab given two we	
Note: Indications marked with * are unapproved indications.	·

I confirm that the above details are correct:

Signed: Date:

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	CRIB	ER	PATIENT:
Name	e:		
Ward:	:		NHI:
Мер	olizu	mal	ь
Re-a	equisi	resc	Severe eosinophilic asthma t required after 12 months (tick boxes where appropriate) cribed by, or recommended by a respiratory physician or clinical immunologist, or in accordance with a protocol or guideline that has been resed by the Health NZ Hospital. Patient must be aged 12 years or older
	and (and and (and and)))	Patient must have a diagnosis of severe eosinophilic asthma documented by a respiratory physician or clinical immunologist Conditions that mimic asthma eg. vocal cord dysfunction, central airway obstruction, bronchiolitis etc. have been excluded Patient has a blood eosinophil count of greater than $0.5 \times 10^{\circ}9$ cells/L in the last 12 months Patient must be adherent to optimised asthma therapy including inhaled corticosteroids (equivalent to at least 1000 mcg per day of fluticasone propionate) plus long acting beta-2 agonist, or budesonide/formoterol as part of the single maintenance and reliever therapy regimen, unless contraindicated or not tolerated
	and (and	C	Patient has had at least 4 exacerbations needing systemic corticosteroids in the previous 12 months, where an exacerbation is defined as either documented use of oral corticosteroids for at least 3 days or parenteral corticosteroids Patient has received continuous oral corticosteroids of at least the equivalent of 10 mg per day over the previous 3 months Treatment is not to be used in combination with subsidised benralizumab Patient has an Asthma Control Test (ACT) score of 10 or less. Baseline measurements of the patient's asthma control using the ACT and oral corticosteroid dose must be made at the time of application, and again at around 52 weeks after the first dose to assess response to treatment
		or	Patient has not previously received an anti-IL5 biological therapy for their severe eosinophilic asthma Patient was refractory or intolerant to previous anti-IL5 biological therapy and Patient was not eligible to continue treatment with previous anti-IL5 biological therapy and discontinued within 12 months of commencing treatment
Re-a	ssessr equisi P	ment i tes (resc	N – Severe eosinophilic asthma t required after 2 years (tick boxes where appropriate) cribed by, or recommended by a respiratory physician or clinical immunologist, or in accordance with a protocol or guideline that has been resed by the Health NZ Hospital.
	and	or	An increase in the Asthma Control Test (ACT) score of at least 5 from baseline Control Test (ACT) score of at least 5 from baseline Exacerbations have been reduced from baseline by 50% as a result of treatment with mepolizumab Reduction in continuous oral corticosteroid use by 50% or by 10 mg/day while maintaining or improving asthma control

I confirm that the above details are correct:

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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:	Name:			
Ward:	NHI:			
Mepolizumab - continued				
INITIATION – eosinophilic granulomatosis with polyangiitis Re-assessment required after 12 months				
Prerequisites (tick boxes where appropriate)				
The patient has eosinophilic granulomatosis with polyangiitis and The patient has trialled and not received adequate benefit from at least one of the following for at least three months (unles contraindicated to all): azathioprine, cyclophosphamide, leflunomide, methotrexate, mycophenolate, or rituximab				
The patient has trialled prednisone for a minimum of thr 7.5 mg per day Or Corticosteroids are contraindicated	ee months and is unable to maintain disease control at doses below			
CONTINUATION – eosinophilic granulomatosis with polyangiitis Re-assessment required after 12 months Prerequisites (tick box where appropriate)				
O Patient has no evidence of clinical disease progression				

I confirm that the above details are correct:

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RS2063 - Adalimumab (Amgevita)

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May 2025

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.

Name: Name: Ward: NHI: Adalimumab (Amgevita)					
Adalimumah (Amgavita)					
Addiniumas (Amgevita)					
INITIATION – Behcet's disease - severe Prerequisites (tick boxes where appropriate) Or prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed NZ Hospital. Or The patient has severe Behcet's disease* that is significantly impacting the patient's quality of life Or The patient has severe ocular, neurological, and/or vasculitic symptoms and has not responded adequately to one or treatment(s) appropriate for the particular symptom(s)					
The patient has severe gastrointestinal, rheumatological and/or mucocutaneous symptoms and has not responded a to two or more treatments appropriate for the particular symptom(s) Note: Indications marked with * are unapproved indications.	dequately				
INITIATION – Hidradenitis suppurativa Re-assessment required after 4 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Hospital. Patient has hidradenitis suppurativa Hurley Stage II or Hurley Stage III lesions in distinct anatomic areas Patient has tried, but had an inadequate response to at least a 90 day trial of systemic antibiotics or patient has demonstration intolerance to or has contraindications for systemic antibiotics and					
Patient has 3 or more active lesions and The patient has a DLQI of 10 or more and the assessment is no more than 1 month old at time of application					
CONTINUATION – Hidradenitis suppurativa Re-assessment required after 2 years Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and					
The patient has a reduction in active lesions (e.g. inflammatory nodules, abscesses, draining fistulae) of 25% or more from and The patient has a DLQI improvement of 4 or more from baseline	n baseline				

May 2025

PRES	SCRIB	BER		PATIENT:	
Name	e:				
Ward	:			NHI:	
Adal	imuı	mab	(An	evita) - continued	
Re-a	ssess	ment	requi	es where appropriate)	
and		Prescri Hospita		, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ	
		and	O	atient has had an initial Special Authority approval for etanercept for severe chronic plaque psoriasis	
			or	Patient has experienced intolerable side effects Patient has received insufficient benefit to meet the renewal criteria for etanercept for severe chronic plaque psoriasis	
	or				
			or	Patient has "whole body" severe chronic plaque psoriasis with a (PASI) score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis Patient has severe chronic localised genital or flexural plaque psoriasis where the plaques or lesions have been present for at least 6 months from the time of initial diagnosis, and with a Dermatology Life Quality Index (DLQI) score greater than 10	
		and))	atient has tried, but had an inadequate response to, or has experienced intolerable side effects from, at least three of the illowing (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, ciclosporin, or acitretin PASI assessment or (DLQI) assessment has been completed for at least the most recent prior treatment course but no inger than 1 month following cessation of each prior treatment course and is no more than 1 month old at the time of opplication	

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Signed.	Date:	
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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	CRIBI	ER			PATIENT:
Name	:				
Ward:					NHI:
Adal	imun	nab (Αn	ngev	ita) - continued
Re-a	ssessr	nent r	equi	red af	psoriasis - severe chronic ter 2 years vhere appropriate)
		(and)	Patie	nt had "whole body" severe chronic plaque psoriasis at the start of treatment
				0	The patient has experienced a 75% or more reduction in PASI score, or is sustained at this level, when compared with the pre-treatment baseline value
			or	0	The patient has a DLQI improvement of 5 or more, when compared with the pre-treatment baseline value
	or				
		and	C	Patie	nt had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment
			or	0	The patient has experienced a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the treatment course baseline values
				0	The patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline value
or					
		and	О —	Patie	nt had severe chronic localised genital or flexural plaque psoriasis at the start of treatment
			٥.	0	The patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline value
			or	0	Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing adalimumab
				_	angrenosum vhere appropriate)
(`	,			
and		ospita		by, or	recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
	O Patient has pyoderma gangrenosum* and				
	() Р	atieı zath	nt has ioprin	received three months of conventional therapy including a minimum of three pharmaceuticals (e.g. prednisone, ciclosporin, e, or methotrexate) and not received an adequate response
Note:	Indic	ations	ma	rked v	vith * are unapproved indications.

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	CRII	BER	PATIENT:
Name	:		
Ward:			NHI:
Adal	imu	mal	b (Amgevita) - continued
Re-a	ssess equis	smer sites Prese	Crohn's disease - adults nt required after 6 months (tick boxes where appropriate) cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health Hospital.
	and	O 	Patient has severe active Crohn's disease
		or	O Patient has extensive small intestine disease affecting more than 50 cm of the small intestine
		or	Patient has evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel resection Patient has an ileostomy or colostomy and has intestinal inflammation
	and	0	Patient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators and corticosteroids
	equis	sites Prese	nt required after 2 years (tick boxes where appropriate) cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health Hospital. CDAI score has reduced by 100 points from the CDAI score, or HBI score has reduced 3 points, from when the patient was initiated on adalimumab CDAI score is 150 or less, or HBI is 4 or less The patient has demonstrated an adequate response to treatment, but CDAI score and/or HBI score cannot be assessed
Re-a	ssess equis	smer sites Prese	Crohn's disease - children nt required after 6 months (tick boxes where appropriate) cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health-Hospital.
and	and	O	Paediatric patient has active Crohn's disease
		or	O Patient has a PCDAI score of greater than or equal to 30 O Patient has extensive small intestine disease
	and	0	Patient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators and corticosteroids

I confirm that the above details are correct:

Signed: Date:

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PRES	CRIBER	PATIENT:
Name		Name:
Ward:		NHI:
Adali	mumab (Amgevita) - continued	
Re-as	NZ Hospital.	accordance with a protocol or guideline that has been endorsed by the Health
	or O PCDAI score has reduced by 10 points from the PCDAI score O PCDAI score is 15 or less Or O The patient has demonstrated an adequate response to treat	
Prere	ATION – Crohn's disease - fistulising seessment required after 6 months quisites (tick boxes where appropriate) Prescribed by, or recommended by any relevant practitioner, or in NZ Hospital.	accordance with a protocol or guideline that has been endorsed by the Health
and	Patient has confirmed Crohn's disease O Patient has one or more complex externally draining e or O Patient has one or more rectovaginal fistula(e) O Patient has complex peri-anal fistula A Baseline Fistula Assessment has been completed and is rectangled.	
Re-as	NZ Hospital. O The number of open draining fistulae have decreased from bor	(e) from baseline as demonstrated by a reduction in the Fistula Assessment

I confirm that the above details are correct:

Signed: Date:

PRES	CRI	BER	PATIENT:
Name	e:		Name:
Ward:	:		NHI:
Adal	imu	ımab	(Amgevita) - continued
Re-a	sses equi	sment sites (t Prescr NZ Ho	cular inflammation - chronic required after 4 months tick boxes where appropriate) ribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health spital. The patient has had an initial Special Authority approval for infliximab for chronic ocular inflammation
		and	Patient has severe uveitis uncontrolled with treatment of steroids and other immunosuppressants with a severe risk of vision loss Patient is 18 years or older and treatment with at least two other immunomodulatory agents has proven ineffective or Patient is under 18 years and treatment with methotrexate has proven ineffective or is not tolerated at a therapeutic dose Patient is under 8 years and treatment with steroids or methotrexate has proven ineffective or is not tolerated at a therapeutic dose; or disease requires control to prevent irreversible vision loss prior to achieving a therapeutic dose of methotrexate
Re-a	sses equi	sment sites (t	N – Ocular inflammation - chronic required after 2 years tick boxes where appropriate) ribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health applial.
u IV	or or	0 !	The patient has had a good clinical response following 12 weeks' initial treatment Following each 2 year treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema)
			Following each 2 year treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old

PRES	CRI	BER	PATIENT:
Name	e:		Name:
Ward	:		NHI:
Adal	imu	ımab	o (Amgevita) - continued
Re-a	sses	Presc NZ Ho	Ocular inflammation - severe t required after 4 months (tick boxes where appropriate) cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ospital. Patient has had an initial Special Authority approval for infliximab for severe ocular inflammation
		and	Patient has severe, vision-threatening ocular inflammation requiring rapid control Treatment with high-dose steroids (intravenous methylprednisolone) followed by high dose oral steroids has proven ineffective at controlling symptoms Patient developed new inflammatory symptoms while receiving high dose steroids Patient is aged under 8 years and treatment with high dose oral steroids and other immunosuppressants has proven ineffective at controlling symptoms
Re-a	sses equi	sites (N – Ocular inflammation - severe t required after 2 years (tick boxes where appropriate) cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.
	or	OO	The patient has had a good clinical response following 3 initial doses Following each 2 year treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema) Following each 2 year treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily or steroid drops less than twice daily if under 18 years old
			Following each 2 year treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < daily, or steroid drops less than twice daily if under 18 years old

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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.

PRESCR	IBER		PATIENT:
Name:			
Ward:			NHI:
Adalim	umab	(An	evita) - continued
Re-asse	ssment i isites (requ tick b ribed	g spondylitis after 6 months s where appropriate) or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
	and	0	tient has had an initial Special Authority approval for etanercept for ankylosing spondylitis
		or	The patient has experienced intolerable side effects
			The patient has received insufficient benefit to meet the renewal criteria for ankylosing spondylitis
or	and and and		tient has a confirmed diagnosis of ankylosing spondylitis for more than six months tient has low back pain and stiffness that is relieved by exercise but not by rest tient has bilateral sacroillitis demonstrated by radiology imaging tient has not responded adequately to treatment with two or more NSAIDs, while patient was undergoing at least 3 months of egular exercise regimen for ankylosing spondylitis Patient has limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by the following BASMI measures: a modified Schober's test of less than or equal to 4 cm and lumbar side flexion measurement of less than or equal to 10 cm (mean of left and right) Patient has limitation of chest expansion by at least 2.5 cm below the average normal values corrected for age and gender BASDAI of at least 6 on a 0-10 scale completed after the 3 month exercise trial, but prior to ceasing any previous armacological treatment and is no more than 1 month old at the time of application
Re-asse	ssment iisites (Presc NZ Ho For ap	requitick bribed ospita	Alter 2 years where appropriate) or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health as where treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10 point provement in BASDAI of 50%, whichever is less

I confirm that the above details are correct:

Signed: Date:

May 2023

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	CRI	BER											P	IT:	
Name	e:												N		
Ward	:												N		
Adal	imu	mab	(An	ıgev	vita) -	continu	ıed								
INITI Re-a	ATIC sses equi:	ON - A sment sites (rthrift required tick by the state of the st	tis - co sired a coxes by, on the NZ	patient Patien Patien At leas maxim Model	t has ea an a anad oliquate or	d by a r d an ini experier eceived	named itial Sp nced in d insuff to met ular co nts with dose) sease	d special Antoleral fificient I thotrexa burse Junited activity	Author able sic benefit kate the	rity appr de effec fit to me erapy o	roval etts et the r mo	for e re	in accordance with a protocol or guidelicercept for oligoarticular course juvenile al criteria for oligoarticular course JIA by where use of methotrexate is limited by the result of th	by toxicity or intolerance
Re-a	sses equi:	sment sites (Presci NZ Ho	requitick bribed spital	ired a oxes by, or l. wing i	initial tre	ears approprimended eatment baselin applica	riate) d by an t, the pa	atient I	vant pra	ractitio t least a	a 50% o	in ac	eas	e with a protocol or guideline that has b ctive joint count and an improvement in inuing 30% improvement in active joint	n physician's global

Way 2023

PRES	SCRII	BER		PATIENT:			
Name	ə:			Name:			
Ward	:			NHI:			
Ada	limu	ımab	(An	mgevita) - continued			
Re-a	equis	sment sites (Presc	requ tick b ribed	itis - polyarticular course juvenile idiopathic uired after 6 months boxes where appropriate) d by, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed alth NZ Hospital.			
		and	0	Patient has had an initial Special Authority approval for etanercept for polyarticular course juvenile idiopathic arthritis (JIA)			
			O Patient has experienced intolerable side effects O Patient has received insufficient benefit to meet the renewal criteria for polyarticular course JIA				
	or	and	\circ	O Moderate or high disease activity (cJADAS10 score of at least 2.5) after a 3-month trial of methotrexate (at the maximum tolerated dose)			
Re-a	equis	sment sites (requ tick b ribed	Arthritis - polyarticular course juvenile idiopathic uired after 2 years boxes where appropriate) by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health al.			
Following initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physical assessment from baseline On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count improvement in physician's global assessment from baseline							

I confirm that the above details are correct:	
Signed:	Date:

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	CRIE	BER		PATIENT:
Name	e:			
Ward	:			NHI:
Adal	imu	mab	(An	ngevita) - continued
Re-a	ssess equis	sment sites (t	requi ick b bed	is - psoriatic red after 6 months oxes where appropriate) by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
		and	C	Patient has had an initial Special Authority approval for etanercept or secukinumab for psoriatic arthritis
			or	O Patient has experienced intolerable side effects O Patient has received insufficient benefit to meet the renewal criteria for psoriatic arthritis
	or		_	
		and and)))	Patient has had active psoriatic arthritis for six months duration or longer Patient has tried and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated) Patient has tried and not responded to at least three months of sulfasalazine or leflunomide at maximum tolerated doses (unless contraindicated)
		and	or	O Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen joints O Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip
			or or	O Patient has CRP level greater than 15 mg/L measured no more than one month prior to the date of this application O Patient has an elevated ESR greater than 25 mm per hour ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months
Re-a	sses	sment	requi	rthritis - psoriatic red after 2 years oxes where appropriate)
and		Prescri NZ Ho		by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health l.
	or	r O f	espo Patie	wing initial treatment, the patient has at least a 50% decrease in swollen joint count from baseline and a clinically significant nse in the opinion of the physician nt demonstrates at least a continuing 30% improvement in swollen joint count from baseline and a clinically significant response opinion of the treating physician

I confirm that the above details are correct:

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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.

RESCRI	IBER		PATIENT:
ame:			
ard:			NHI:
dalimı	umab	(Am	ngevita) - continued
NITIATIO Re-asses	ON – A ssment isites (Arthriti t requir (tick bo	tis - rheumatoid ired after 6 months ioxes where appropriate) by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
ind		\bigcirc	The patient has had an initial Special Authority approval for etanercept for rheumatoid arthritis
	and	_	O The patient has experienced intolerable side effects
		or	The patient has received insufficient benefit from etanercept to meet the renewal criteria for rheumatoid arthritis
or			
	and	O	Patient has had rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic citrullinated peptide (CCP) antibody positive) for six months duration or longer Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance
	and	O	Patient has tried and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated)
	and		Patient has tried and not responded to at least three months of methotrexate in combination with sulfasalazine and hydroxychloroquisulphate at maximum tolerated doses (unless contraindicated)
		or	O Patient has tried and not responded to at least three months of methotrexate in combination with the maximum tolerated dose of ciclosporin
			O Patient has tried and not responded to at least three months of therapy at the maximum tolerated dose of leflunomide alone or in combination with methotrexate
	and		O Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen joints
		or	O Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip
Re-asses	ssment	t requi	arthritis - rheumatoid ired after 2 years oxes where appropriate)
0	Presc	`	by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
nd			wing initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant onse to treatment in the opinion of the physician
or			ubsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and ically significant response to treatment in the opinion of the physician

I confirm that the above details are correct:

Signed: Date:

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	CRI	BER	PATIENT:
Name	e:		
Ward	:		NHI:
Adal	imu	ımab (Amgevita) - continued
	equi	sites (tic	's disease - adult-onset (AOSD) k boxes where appropriate) ed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and		Hospital	
		and	The patient has had an initial Special Authority approval for etanercept and/or tocilizumab for (AOSD)
			O Patient has experienced intolerable side effects from etanercept and/or tocilizumab Patient has received insufficient benefit from at least a three-month trial of etanercept and/or tocilizumab
			Patient has received insulincient benefit from at least a timee-month that of etanercept and/or tocilizumab
	or	and	Patient diagnosed with AOSD according to the Yamaguchi criteria
		and	Patient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, NSAIDs and methotrexate
		and	Patient has persistent symptoms of disabling poorly controlled and active disease
and		Prescrib NZ Hosp	ed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ital.
	and	_	tient has active ulcerative colitis
		or	Patient's SCCAI score is greater than or equal to 4
			Patient's PUCAI score is greater than or equal to 20
	and	O Pa	tient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators d systemic corticosteroids
	and	\sim	rgery (or further surgery) is considered to be clinically inappropriate
Re-a	sses	sment re	- ulcerative colitis quired after 2 years k boxes where appropriate)
and	C	Prescrib NZ Hosp	ed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ital.
	or	O Th	e SCCAI score has reduced by 2 points or more from the SCCAI score when the patient was initiated on biologic therapy
		O Th	e PUCAI score has reduced by 10 points or more from the PUCAI score when the patient was initiated on biologic therapy
-			

I confirm that the above details are correct:

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I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER		BER	PATIENT:	PATIENT:		
Name	e:					
Ward	/ard:NHI:					
Adal	imu	ımak	(Amgevita) - continued			
Re-a	sses equi:	smen sites	ndifferentiated spondyloarthiritis required after 6 months tick boxes where appropriate)			
and		Preso	ribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endors tal.	ed by the Health NZ		
	anc		Patient has undifferentiated peripheral spondyloarthritis* with active peripheral joint arthritis in at least four joints frow wrist, elbow, knee, ankle, and either shoulder or hip	om the following:		
	and	O 1	Patient has tried and not responded to at least three months of each of methotrexate, sulphasalazine and leflunom tolerated doses (unless contraindicated)	ide, at maximum		
		or	O Patient has a CRP level greater than 15 mg/L measured no more than one month prior to the date of this app	olication		
		or	O Patient has an ESR greater than 25 mm per hour measured no more than one month prior to the date of this	application		
			ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 has done so for more than three months	mg per day and		
Note	: Ind	licatio	s marked with * are unapproved indications.			
Re-a	sses equi:	smen sites Preso	N – undifferentiated spondyloarthiritis required after 2 years tick boxes where appropriate) ribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been spital.			
	or	0	Following initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinical response to treatment in the opinion of the physician The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically			
			response in the opinion of the treating physician	, digrimodrit		
Re-a	sses equi:	smen sites	Inflammatory bowel arthritis – axial required after 6 months tick boxes where appropriate) ribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorse	ed by the Health NZ		
and		Hosp				
	and		Patient has a diagnosis of active ulcerative colitis or active Crohn's disease			
	and		Patient has axial inflammatory pain for six months or more Patient is unable to take NSAIDs			
	and	0	Patient has unequivocal sacroiliitis demonstrated by radiological imaging or MRI			
	and	0	Patient has not responded adequately to prior treatment consisting of at least 3 months of an exercise regime sup physiotherapist	ervised by a		
	and	O	A BASDAI of at least 6 on a 0-10 scale completed after the 3 month exercise trial, but prior to ceasing any previous treatment	s pharmacological		

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NHI:
in accordance with a protocol or guideline that has been endorsed by the Health 4 or more points from pre-treatment baseline on a 10 point scale, or an rdance with a protocol or guideline that has been endorsed by the Health NZ e Crohn's disease following: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder, set three months of methotrexate, or azathioprine at a maximum tolerated
4 or more points from pre-treatment baseline on a 10 point scale, or an ordance with a protocol or guideline that has been endorsed by the Health NZ e Crohn's disease collowing: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder, ast three months of methotrexate, or azathioprine at a maximum tolerated
4 or more points from pre-treatment baseline on a 10 point scale, or an ordance with a protocol or guideline that has been endorsed by the Health NZ e Crohn's disease collowing: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder, ast three months of methotrexate, or azathioprine at a maximum tolerated
4 or more points from pre-treatment baseline on a 10 point scale, or an ordance with a protocol or guideline that has been endorsed by the Health NZ e Crohn's disease collowing: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder, ast three months of methotrexate, or azathioprine at a maximum tolerated
4 or more points from pre-treatment baseline on a 10 point scale, or an ordance with a protocol or guideline that has been endorsed by the Health NZ e Crohn's disease collowing: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder, ast three months of methotrexate, or azathioprine at a maximum tolerated
rdance with a protocol or guideline that has been endorsed by the Health NZ e Crohn's disease following: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder, set three months of methotrexate, or azathioprine at a maximum tolerated
e Crohn's disease collowing: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder, dist three months of methotrexate, or azathioprine at a maximum tolerated
e Crohn's disease ollowing: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder, ast three months of methotrexate, or azathioprine at a maximum tolerated
e Crohn's disease ollowing: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder, ast three months of methotrexate, or azathioprine at a maximum tolerated
ollowing: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder, ast three months of methotrexate, or azathioprine at a maximum tolerated
ast three months of methotrexate, or azathioprine at a maximum tolerated
st three months of sulphasalazine at a maximum tolerated dose (unless
,
ured no more than one month prior to the date of this application
receiving prednisone therapy at a dose of greater than 5 mg per day and
in accordance with a protocol or guideline that has been endorsed by the Health
decrease in active joint count from baseline and a clinically significant
ent in active joint count from baseline in the opinion of the treating physician
(

PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Palivizumab				
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Palivizumab to be administered during the annual RSV season and Infant was born in the last 12 months and Infant was born at less than 32 weeks zero days' or O Child was born in the last 24 months and O Child has severe lung, airway, neurological support (see Note A) in the community O Child has haemodynamically significated and O Child has unoperated simple coor Or O Child has unoperated or surgical or O Child has unoperated or surgical or	pestation or neuromuscular disease that requires ongoing ventilatory/respiratory nt heart disease ingenital heart disease with significant left to right shunt (see Note ally palliated complex congenital heart disease			
or	opertension (see Note C) oft ventricular (LV) failure (see Note D) ncy, confirmed by an immunologist, but has not received a stem cell			
or	te E) that increase susceptibility to life-threatening viral respiratory			

I confirm that the above details are corre	ct
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Signed.	Date:	
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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Palivizumab - continued	
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Palivizumab to be administered during the annual RSV season and O Child was born in the last 24 months and O Child has severe lung, airway, neurological or neuromun Note A) in the community O Child has haemodynamically significant heart distant O Child has unoperated simple congenital here or O Child has unoperated or surgically palliated or Or Child has severe pulmonary hypertension (or Or Child has moderate or severe left ventricular or Child has moderate or Severe left	scular disease that requires ongoing ventilatory/respiratory support (see ease art disease with significant left to right shunt (see Note B) d complex congenital heart disease see Note C)
	crease susceptibility to life-threatening viral respiratory infections,

Note:

- a) Ventilatory/respiratory support includes those on home oxygen, CPAP/VPAP and those with tracheostomies in situ managed at home
- b) Child requires/will require heart failure medication, and/or child has significant pulmonary hypertension, and/or infant will require surgical palliation/definitive repair within the next 3 months
- c) Mean pulmonary artery pressure more than 25 mmHg
- d) LV Ejection Fraction less than 40%
- e) Inborn errors of immunity include, but are not limited to, IFNAR deficiencies

I confirm that the above details are correct:	
Signed:	Date:

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PRESCRIBER		PATIENT:	
Name:		Name:	
Ward:		NHI:	
Gemtuzumab oz	zogamicin		
INITIATION Prerequisites (tick b	boxes where appropriate)		
O Patie	ent has not received prior chemotherapy for this condition		
	ent has de novo CD33-positive acute myeloid leukaemia		
O Patient does not have acute promyelocytic leukaemia			
and Gem	ntuzumab ozogamicin will be used in combination with stan	dard anthracycline and cytarabine (AraC)	
O Patie	ent is being treated with curative intent		
_	ent's disease risk has been assessed by cytogenetic testing	g to be good or intermediate	
	ent must be considered eligible for standard intensive remis rabine (AraC)	ssion induction chemotherapy with standard anthracycline and	
	ntuzumab ozogamicin to be funded for one course only (one arate doses)	e dose at 3 mg per m ² body surface area or up to 2 vials of 5 mg as	

Note: Acute myeloid leukaemia excludes acute promyelocytic leukaemia and acute myeloid leukaemia that is secondary to another haematological disorder (eg myelodysplasia or myeloproliferative disorder).

I confirm that the above details are correct:	
Signed:	Date:

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		ER	PATIENT:
Name):		
Ward:	:		NHI:
Benr	alizu	ıma	b
Re-a	ssessi equisi P e	resc	Revere eosinophilic asthma t required after 12 months (tick boxes where appropriate) ribed by, or recommended by a respiratory physician or clinical immunologist, or in accordance with a protocol or guideline that has been sed by the Health NZ Hospital. Patient must be aged 12 years or older
	and (and and (and ()))	Patient must have a diagnosis of severe eosinophilic asthma documented by a respiratory physician or clinical immunologist Conditions that mimic asthma eg. vocal cord dysfunction, central airway obstruction, bronchiolitis etc. have been excluded Patient has a blood eosinophil count of greater than 0.5 × 10^9 cells/L in the last 12 months Patient must be adherent to optimised asthma therapy including inhaled corticosteroids (equivalent to at least 1000 mcg per day of fluticasone propionate) plus long-acting beta-2 agonist, or budesonide/formoterol as part of the anti-inflammatory reliever therapy plus maintenance regimen, unless contraindicated or not tolerated
	and and and	C	Patient has had at least 4 exacerbations needing systemic corticosteroids in the previous 12 months, where an exacerbation is defined as either documented use of oral corticosteroids for at least 3 days or parenteral corticosteroids Patient has received continuous oral corticosteroids of at least the equivalent of 10 mg per day over the previous 3 months Treatment is not to be used in combination with subsidised mepolizumab Patient has an Asthma Control Test (ACT) score of 10 or less. Baseline measurements of the patient's asthma control using the ACT and oral corticosteroid dose must be made at the time of application, and again at around 52 weeks after the first dose to assess response to treatment
		or	Patient has not previously received an anti-IL5 biological therapy for their severe eosinophilic asthma Patient was refractory or intolerant to previous anti-IL5 biological therapy and Patient was not eligible to continue treatment with previous anti-IL5 biological therapy and discontinued within 12 months of commencing treatment
Re-a	ssessi equisi P	resc	N – Severe eosinophilic asthma t required after 2 years (tick boxes where appropriate) ribed by, or recommended by a respiratory physician or clinical immunologist, or in accordance with a protocol or guideline that has been seed by the Health NZ Hospital. An increase in the Asthma Control Test (ACT) score of at least 5 from baseline
	and	or	Exacerbations have been reduced from baseline by 50% as a result of treatment with benralizumab Reduction in continuous oral corticosteroid use by 50% or by 10 mg/day while maintaining or improving asthma control

I confirm that the above details are correct:

Signed: Date:

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:	Name:
Ward:	NHI:
Jstekinumab	
INITIATION – Crohn's disease - adult Re-assessment required after 6 months Prerequisites (tick boxes where appro	s priate)
or Patient is currently on to below at the time of cor Patient has active	
and Patient has	had an initial approval for prior biologic therapy for Crohn's disease and has experienced intolerable side is sufficient benefit to meet renewal criteria
and	nt meets the initiation criteria for prior biologic therapies for Crohn's disease r biologics for Crohn's disease are contraindicated
or therapy O CDAI score is 150 or The patient has e	priate) educed by 100 points, or HBI score has reduced by 3 points, from when the patient was initiated on biologic or less, or HBI is 4 or less experienced an adequate response to treatment, but CDAI score and/or HBI score cannot be assessed
INITIATION – Crohn's disease - child Re-assessment required after 6 months Prerequisites (tick boxes where appro	S
Patient is currently on to below at the time of cor	
Patient has benefit to m	had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient neet renewal criteria In the meets the initiation criteria for prior biologic therapies for Crohn's disease In biologics for Crohn's disease are contraindicated
Note: Indication marked with * is an un	approved indication.

I confirm that the above details are correct:

Cianad.	Data.	
Siurieu.	 Date.	

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:	Name:
Ward:	NHI:
Ustekinumab - continued	
CONTINUATION - Crohn's disease - ch	ildren*
Re-assessment required after 12 months Prerequisites (tick boxes where appropri	ate)
or PCDAI score has re	duced by 10 points from when the patient was initiated on biologic therapy
O PCDAI score is 15 o	or less
The patient has exp	erienced an adequate response to treatment, but CDAI score cannot be assessed
and	
	red at a dose no greater than 90 mg every 8 weeks
Note: Indication marked with * is an unap	proved indication.
or Delow at the time of common or Patient has active une of and Patient has have effects or insured or Patient has have effects or insured or and Patient has have effects or insured or and or a	atment with ustekinumab commenced prior to 1 February 2023 and met all remaining criteria (criterion 2) nencing treatment
CONTINUATION – ulcerative colitis Re-assessment required after 12 months Prerequisites (tick boxes where appropri	ate) as reduced by 2 points or more from the SCCAI score since initiation on biologic therapy
	duced by 10 points or more from the PUCAI score since initiation on biologic therapy*
O Ustekinumab will be used	at a dose no greater than 90 mg intravenously every 8 weeks
Note: Criterion marked with * is for an una	approved indication.

PRESCRIBER				PATIENT:
Name:				Name:
Ward: .				NHI:
Vedoli	zun	nab		
Re-ass	essn	nent r	equ	's disease - adults ired after 6 months oxes where appropriate)
а	nd) _F	atie	nt has active Crohn's disease
		or (С	Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria (unless contraindicated)
		(C	Patient has a CDAI score of greater than or equal to 300, or HBI score of greater than or equal to 10
		or (C	Patient has extensive small intestine disease affecting more than 50 cm of the small intestine
		or (C	Patient has evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel resection
		or (С	Patient has an ileostomy or colostomy, and has intestinal inflammation
а	nd		_	
		(J	Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response) from prior therapy with immunomodulators and corticosteroids
		or (С	Patient has experienced intolerable side effects from immunomodulators and corticosteroids
		or (C	Immunomodulators and corticosteroids are contraindicated
Re-ass	essn	nent r	equ	crohn's disease - adults ired after 2 years oxes where appropriate)
		or	С	CDAI score has reduced by 100 points, or HBI score has reduced by 3 points, from when the patient was initiated on biologic therapy
		(C	CDAI score is 150 or less, or HBI is 4 or less
		or (C	The patient has experienced an adequate response to treatment, but CDAI score and/or HBI score cannot be assessed
а	nd) v	'edo	lizumab to administered at a dose no greater than 300 mg every 8 weeks

I confirm that the above details are correct:	
Signed:	Date:

May 2025

RESCRIE	BER		PATIENT:
ame:			Name:
ard:			NHI:
edolizu	mak) - co	ontinued
le-assess	men	t requ	a's disease - children* uired after 6 months poxes where appropriate)
and	0	Paec	diatric patient has active Crohn's disease
		0	Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria (unless contraindicated)
	or	0	Patient has a Paediatric Crohn's Disease Activity Index (PCDAI) score of greater than or equal to 30
	or	0	Patient has extensive small intestine disease
and		_	
	or or	\circ	Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response) from prior therapy with immunomodulators and corticosteroids
		0	Patient has experienced intolerable side effects from immunomodulators and corticosteroids
		0	Immunomodulators and corticosteroids are contraindicated
ote: Indi	catio	n maı	ked with * is an unapproved indication.
e-assess	men	t requ	Crohn's disease - children* uired after 2 years boxes where appropriate)
	or	0	PCDAI score has reduced by 10 points from when the patient was initiated on biologic therapy
		0	PCDAI score is 15 or less
	or	0	The patient has experienced an adequate response to treatment, but CDAI score cannot be assessed
and	0	Vedo	olizumab to administered at a dose no greater than 300mg every 8 weeks
ote: Indi	catio	n mai	ked with * is an unapproved indication.

I confirm that the above details are correct:	
Signed:	Date:

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 PATIE				PATIENT:
Name	:			Name:
Ward:				NHI:
Vedo	lizu	mal) - cc	ontinued
Re-a	ssess	men	t requ	ative colitis ired after 6 months boxes where appropriate)
	(and	C	Patie	ent has active ulcerative colitis
		or	0	Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria (unless contraindicated)
			0	Patient has a SCCAI score is greater than or equal to 4
		or	0	Patient's PUCAI score is greater than or equal to 20*
	and			
			0	Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response) from prior therapy with immunomodulators and corticosteroids
		or	0	Patient has experienced intolerable side effects from immunomodulators and corticosteroids
		or	0	Immunomodulators and corticosteroids are contraindicated
Note	: Indic	catio	n mar	ked with * is an unapproved indication.
Re-a	ssess	men	t requ	Ilcerative colitis irred after 2 years poxes where appropriate)
		or	0	The SCCAI score has reduced by 2 points or more from the SCCAI score since initiation on biologic therapy
			0	The PUCAI score has reduced by 10 points or more from the PUCAI score since initiation on biologic therapy *
	and (С	Vedo	lizumab will be used at a dose no greater than 300 mg intravenously every 8 weeks
Note	: Indic	catio	n mar	ked with * is an unapproved indication.

I confirm that the above details are correct:

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Signed.	Date:	
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May 2025

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:	Vard:NHI:				
Brentuxima	b				
Re-assessme	relapsed/refractory Hodgkin lymphoma It required after 6 months (tick boxes where appropriate)				
OI	Patient has relapsed/refractory CD30-positive Hodgkin lymphoma after two or more lines of chemotherapy and Patient is ineligible for autologous stem cell transplant				
	Patient has relapsed/refractory CD30-positive Hodgkin lymphoma and Patient has previously undergone autologous stem cell transplant				
and and and and	Patient has not previously received funded brentuximab vedotin Response to brentuximab vedotin treatment is to be reviewed after a maximum of 6 treatment cycles Brentuximab vedotin to be administered at doses no greater than 1.8 mg/kg every 3 weeks				
Re-assessme	DN – relapsed/refractory Hodgkin lymphoma nt required after 9 months (tick boxes where appropriate)				
and O	Patient has achieved a partial or complete response to brentuximab vedotin after 6 treatment cycles Treatment remains clinically appropriate and the patient is benefitting from treatment and treatment is being tolerated				
and	Patient is to receive a maximum of 16 total cycles of brentuximab vedotin treatment				
INITIATION – anaplastic large cell lymphoma Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)					
and	Patient has relapsed/refractory CD30-positive systemic anaplastic large cell lymphoma				
and and and	Patient has an ECOG performance status of 0-1 Patient has not previously received brentuximab vedotin Response to brentuximab vedotin treatment is to be reviewed after a maximum of 6 treatment cycles				
anu	Brentuximab vedotin to be administered at doses no greater than 1.8 mg/kg every 3 weeks				

I confirm that the above details are correct: Signed: Date:

PRES	CRIBER		PATIENT:			
Name	:		Name:			
Ward:			NHI:			
Bren	tuximal	• continued				
		N – anaplastic large cell lymphoma t required after 9 months				
Prere	equisites	(tick boxes where appropriate)				
	O	Patient has achieved a partial or complete response to brentux	ximab vedotin after 6 treatment cycles			
	and	Treatment remains clinically appropriate and the patient is benefitting from treatment and treatment is being tolerated				
	and	Patient is to receive a maximum of 16 total cycles of brentuxim	nab vedotin treatment			

May 2025

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:	Name:
Ward:	NHI:
Trastuzumab (Herzuma)	
INITIATION – early breast cancer Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) The patient has early breast cancer expressing HER-2 IHC 3 and	
Maximum cumulative dose of 106 mg/kg (12 months' treatme	ent)
CONTINUATION – early breast cancer* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
The patient received prior adjuvant trastuzumab treatment or The patient has not previously received lapatinib The patient discontinued lapatinib within 3 month on lapatinib He cancer has not progressed at any time point or Trastuzumab will not be given in combination with or Trastuzumab to be administered in combinand Patient has not received prior treatment for	treatment for HER-2 positive metastatic breast cancer as due to intolerable side effects and the cancer did not progress whilst during the previous 12 months whilst on trastuzumab h pertuzumab ation with pertuzumab their metastatic disease and has had a treatment-free interval of at ant chemotherapy treatment and diagnosis of metastatic breast cancer
Or Patient has previously discontinued treatment with tras or disease progression and Patient has signs of disease progression and	tuzumab in the metastatic setting for reasons other than severe toxicity
Note: * For patients with relapsed HER-2 positive disease who have previou	

I confirm that the above details are correct:

Signed: Date:

May 2020

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:	
Vard:	NHI:
rastuzuma	ab (Herzuma) - continued
	metastatic breast cancer nt required after 12 months
Prerequisites	s (tick boxes where appropriate)
and	The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)
OI	O The patient has not previously received lapatinib treatment for HER-2 positive metastatic breast cancer
	O The patient discontinued lapatinib within 3 months due to intolerable side effects and the cancer did not progress whilst on lapatinib
and	· · ·
OI	Trastuzumab will not be given in combination with pertuzumab
	O Trastuzumab to be administered in combination with pertuzumab
	Patient has not received prior treatment for their metastatic disease and has had a treatment-free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer
	and The patient has good performance status (ECOG grade 0-1)
and	
O	Trastuzumab to be discontinued at disease progression
CONTINUATI	ON – metastatic breast cancer
	nt required after 12 months s (tick boxes where appropriate)
aı	O The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)
	The cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab
	O Trastuzumab to be discontinued at disease progression
or	
aı	O Patient has previously discontinued treatment with trastuzumab for reasons other than severe toxicity or disease progression and
	O Patient has signs of disease progression
aı	O Disease has not progressed during previous treatment with trastuzumab
	gastric, gastro-oesophageal junction and oesophageal cancer nt required after 12 months
	s (tick boxes where appropriate)
O	The patient has locally advanced or metastatic gastric, gastro-oesophageal junction or oesophageal cancer expressing HER-2 IHC 2+ FISH+ or IHC3+ (or other current technology)
and	Patient has an ECOG score of 0-2

I confirm that the above details are correct:

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Trastuzumab (Herzuma) - continued			
CONTINUATION – gastric, gastro-oesophageal junction and oesophage Re-assessment required after 12 months	eal cancer		
Prerequisites (tick boxes where appropriate)			
O The cancer has not progressed at any time point during the	previous 12 months whilst on trastuzumab		
O Trastuzumab to be discontinued at disease progression			

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:	Name:	
Ward:	NHI:	
Trastuzumab deruxtecan		
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)		
Patient has metastatic breast cancer expressing HER-2 IHC3- and Patient has previously received trastuzumab and chemotherap and The patient has received prior therapy for metastatic dis	by, separately or in combination	
The patient developed disease recurrence during, or wit and Patient has a good performance status (ECOG 0-1) and Patient has not received prior funded trastuzumab deruxtecan and Treatment to be discontinued at disease progression		
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)		
The cancer has not progressed at any time point during the prand Treatment to be discontinued at disease progression Note: Prior or adjuvant therapy includes anthracycline, other chemotherapy, by		

I confirm that the above details are correct:

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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:
Bevacizumab	
Prerequisites (tick before or Patier or and	ctable hepatocellular carcinoma red after 6 months boxes where appropriate) In this currently on treatment with bevacizumab, and met all remaining criteria prior to commencing treatment Patient has locally advanced or metastatic, unresectable hepatocellular carcinoma Patient has preserved liver function (Child-Pugh A) Transarterial chemoembolisation (TACE) is unsuitable Patient has not received prior systemic therapy for the treatment of hepatocellular carcinoma Patient received funded lenvatinib before 1 March 2025
CONTINUATION – ur Re-assessment requi Prerequisites (tick bo	
Re-assessment requi	ced or metastatic ovarian cancer red after 4 months oxes where appropriate)
and Bevac	The patient has FIGO Stage IV epithelial ovarian, fallopian tube, or primary peritoneal cancer The patient has previously untreated advanced (FIGO Stage IIIB or IIIC) epithelial ovarian, fallopian tube, or primary peritoneal cancer Debulking surgery is inappropriate The cancer is sub-optimally debulked (maximum diameter of any gross residual disease greater than 1cm) Designation of the cancer is sub-optimally debulked (maximum diameter of any gross residual disease greater than 1cm) Designation of the cancer is sub-optimally debulked (maximum diameter of any gross residual disease greater than 1cm)

I confirm that the above details are correct:

PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Bevacizumab - continued				
CONTINUATION – advanced or metastatic ovarian cancer Re-assessment required after 4 months				
Prerequisites (tick box where appropriate)				
O No evidence of disease progression				
INITIATION – Recurrent Respiratory Papillomatosis Re-assessment required after 12 months				
Prerequisites (tick boxes where appropriate)				
O Maximum of 6 doses				
The patient has recurrent respiratory papillomatosis				
O The treatment is for intra-lesional administration				
CONTINUATION – Recurrent Respiratory Papillomatosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)				
O Maximum of 6 doses				
The treatment is for intra-lesional administration				
O There has been a reduction in surgical treatments or disease	regrowth as a result of treatment			
INITIATION – Ocular Conditions Prerequisites (tick boxes where appropriate)				
O Ocular neovascularisation				
O Exudative ocular angiopathy				

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Signed.	Date.
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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Inotuzumab ozogamicin	
INITIATION Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	
O Patient has relapsed or refractory CD22-positive B-cell acute I	ymphoblastic leukaemia/lymphoma, including minimal residual disease
Patient has ECOG performance status of 0-2	
Patient has Philadelphia chromosome positive B-0 and Patient has previously received a tyrosine kinase in	
O Patient has received one prior line of treatment involving	j intensive chemotherapy
O Treatment is to be administered for a maximum of 3 cycles	
CONTINUATION Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	
O Patient is not proceeding to a stem cell transplant and	
O Patient has experienced complete disease response	
O Patient has experienced complete remission with incom	plete haematological recovery
Treatment with inotuzumab ozogamicin is to cease after a total	Il duration of 6 cycles

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Signed.	Date:	
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Form RS1203 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 408

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:	Name:		
Ward:	NHI:		
Basiliximab			
INITIATION Prerequisites (tick box where appropriate)			
O For use in solid organ transplants			

I confirm that the above details are correct:

Signed: Date:

PRES	CRIB	ER		PATIENT:
Name	e:			
Ward	:			NHI:
Ritu	xima	b (M	abthe	ra)
Re-a	ssess equis i	ment ites (requ tick b ribed	atoid arthritis - prior TNF inhibitor use red after 4 months oxes where appropriate) by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
unu		and	O	The patient has had an initial community Special Authority approval for at least one of etanercept and/or adalimumab for rheumatoid arthritis The patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept Following at least a four month trial of adalimumab and/or etanercept, the patient did not meet the renewal criteria for adalimumab and/or etanercept for rheumatoid arthritis
	and	or	O O	Rituximab to be used as an adjunct to methotrexate or leflunomide therapy Patient is contraindicated to both methotrexate and leflunomide, requiring rituximab monotherapy to be used
	and (<u>С</u>	Maxii	num of two 1,000 mg infusions of rituximab given two weeks apart

ESCRIBER			PATIENT:
e:			Name:
:			NHI:
xima	b (N	1abthe	era) - continued
IATION	N – r men	heum t requ	natoid arthritis - TNF inhibitors contraindicated uired after 4 months poxes where appropriate)
ОР		ribed	by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
(and	C	Treat	tment with a Tumour Necrosis Factor alpha inhibitor is contraindicated
and	C		ent has had severe and active erosive rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic linated peptide (CCP) antibody positive) for six months duration or longer
and	\sim	maxi	ent has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a mum tolerated dose
and			ent has tried and not responded to at least three months of oral or parenteral methotrexate in combination with sulfasalazine and oxychloroquine sulphate (at maximum tolerated doses)
	or	\circ	Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with the maximum tolerated dose of cyclosporin
	or	\circ	Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with intramuscula gold
and			Patient has tried and not responded to at least three months of therapy at the maximum tolerated dose of leflunomide alone or in combination with oral or parenteral methotrexate
anu	or	0	Patient has persistent symptoms of poorly controlled and active disease in at least 20 swollen, tender joints
		0	Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip
and		0	Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application
	or	0	C-reactive protein levels not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months
and		_	
	or	\bigcirc	Rituximab to be used as an adjunct to methotrexate or leflunomide therapy
		\bigcirc	Patient is contraindicated to both methotrexate and leflunomide, requiring rituximab monotherapy to be used
and	\supset	Mani	mum of two 1,000 mg infusions of rituximab given two weeks apart

I confirm that the above details are correct:		
Signed:	Date:	

May 2025

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.

		PATIENT:
e:		
d:		NHI:
ximab (I	Mabth	era) - continued
assessmer	nt requ	heumatoid arthritis - re-treatment in 'partial responders' to rituximab uired after 4 months poxes where appropriate)
		by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
Hosp		by, or recommended by a medinatologist, or in accordance with a protocor or guideline that has been endorsed by the meaning to
	0	At 4 months following the initial course of rituximab infusions the patient had between a 30% and 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician
or	0	At 4 months following the second course of rituximab infusions the patient had at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician
	0	At 4 months following the third and subsequent courses of rituximab infusions, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician
and and	Ritu	kimab re-treatment not to be given within 6 months of the previous course of treatment
	0	Rituximab to be used as an adjunct to methotrexate or leflunomide therapy
or	0	Patient is contraindicated to both methotrexate and leflunomide, requiring rituximab monotherapy to be used
and	Maxi	mum of two 1,000 mg infusions of rituximab given two weeks apart
assessmer	nt requ	heumatoid arthritis - re-treatment in 'responders' to rituximab uired after 4 months poxes where appropriate)
O Pres		by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
or	0	At 4 months following the initial course of rituximab infusions the patient had at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician
	0	At 4 months following the second and subsequent courses of rituximab infusions, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician
and _	Ritu	kimab re-treatment not to be given within 6 months of the previous course of treatment
	0	Rituximab to be used as an adjunct to methotrexate or leflunomide therapy
or	0	Patient is contraindicated to both methotrexate and leflunomide, requiring rituximab monotherapy to be used
and		mum of two 1,000 mg infusions of rituximab given two weeks apart

I confirm that the above details are correct:

RS1922 - Adalimumab (Humira - Alternative brand)

Arthritis - polyarticular course juvenile idiopathic - INITIATION	421
Arthritis - polyarticular course juvenile idiopathic - CONTINUATION	421
Arthritis - psoriatic - INITIATION	421
Arthritis - psoriatic - CONTINUATION	422
Arthritis – oligoarticular course juvenile idiopathic - INITIATION	420
Arthritis – oligoarticular course juvenile idiopathic - CONTINUATION	421
Arthritis – rheumatoid - INITIATION	422
Arthritis – rheumatoid - CONTINUATION	422
Behcet's disease – severe - INITIATION	413
Behcet's disease – severe - CONTINUATION	413
Crohn's disease - adult - INITIATION	
Crohn's disease - adult - CONTINUATION	
Crohn's disease - children - INITIATION	417
Crohn's disease - children - CONTINUATION	417
Crohn's disease - fistulising - INITIATION	
Crohn's disease - fistulising - CONTINUATION	418
Hidradenitis suppurativa - INITIATION	
Hidradenitis suppurativa - CONTINUATION	414
Ocular inflammation – chronic - INITIATION	418
Ocular inflammation – chronic - CONTINUATION	
Ocular inflammation – severe - INITIATION	
Ocular inflammation – severe - CONTINUATION	
Psoriasis - severe chronic plaque - INITIATION	414
Psoriasis - severe chronic plaque - CONTINUATION	415
Pyoderma gangrenosum - INITIATION	
Pyoderma gangrenosum - CONTINUATION	416
Still's disease – adult-onset (AOSD) - INITIATION	423
Still's disease – adult-onset (AOSD) - CONTINUATION	423
Ankylosing spondylitis - INITIATION	420
Ankylosing spondylitis - CONTINUATION	420

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:	Name:				
Ward:					
Adalimumab (Humira - Alternative brand)					
INITIATION – Behcet's disease – severe Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Orescribed by, or recommended by any relevant practitioner, or in activity and NZ Hospital.	ecordance with a protocol or guideline that has been endorsed by the Health				
O Patient has developed symptoms of loss of disease con (Amgevita) and clinician attributes this loss of disease re	trol following a minimum of 4 weeks treatment with adalimumab esponse to a change in treatment regimen				
Patient has received a maximum of 6 months treatment with A and					
Patient has previously had a Special Authority approval for the and Adalimumab to be administered at doses no greater than 40 n					
CONTINUATION – Behcet's disease – severe Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Or Prescribed by, or recommended by any relevant practitioner, or in act NZ Hospital. and The patient has had a good clinical response to treatment with and Adalimumab to be administered at doses no greater than 40 metals.					
INITIATION – Hidradenitis suppurativa Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a dermatologist or Practitioner or guideline that has been endorsed by the Health NZ Hospital. and	n the recommendation of a dermatologist, or in accordance with a protocol				
or					
and Patient has previously had a Special Authority approval for the and Adalimumab to be administered at doses no greater than 40 n	Humira brand of adalimumab for this indication				

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.

CRIBER		PATIENT:		
:		Name:		
		NHI:		
mumab	o (Humira - Alternative brand) - continued			
ssessmen	t required after 6 months			
		n the recommendation of a dermatologist, or in accordance with a protocol		
The patient has a reduction in active lesions (e.g. inflammatory nodules, abscesses, draining fistulae) of 25% or more from baseline and The patient has a Dermatology Quality of Life Index improvement of 4 or more from baseline and Adalimumab is to be administered at doses no greater than 40mg every 7 days. Fortnightly dosing has been considered				
ssessmen	t required after 6 months			
Preso	cribed by, or recommended by a dermatologist or Practitioner o	n the recommendation of a dermatologist, or in accordance with a protocol		
or	O Patient has developed symptoms of loss of disease con	trol following a minimum of 4 weeks treatment with adalimumab esponse to a change in treatment regimen		
and on and on and on one of the o	Patient has previously had a Special Authority approval for the	Humira brand of adalimumab for this indication		
	mumak FINUATIO Sesessmen equisites O Preso and and O Preso or gu and or gu or gu or gu or gu and or gu and or gu or gu or gu	mumab (Humira - Alternative brand) - continued FINUATION - Hidradenitis suppurativa sessment required after 6 months requisites (tick boxes where appropriate) Prescribed by, or recommended by a dermatologist or Practitioner or or guideline that has been endorsed by the Health NZ Hospital. The patient has a reduction in active lesions (e.g. inflammator and Adalimumab is to be administered at doses no greater than 40 Adalimumab is to be administered at doses no greater than 40 Adalimumab is to be administered at doses no greater than 40 ATION - Psoriasis - severe chronic plaque sessment required after 6 months requisites (tick boxes where appropriate) Prescribed by, or recommended by a dermatologist or Practitioner or or guideline that has been endorsed by the Health NZ Hospital. The patient has experienced intolerable side effects from Or Patient has developed symptoms of loss of disease con (Amgevita) and clinician attributes this loss of disease reand Patient has received a maximum of 6 months treatment with A and Patient has previously had a Special Authority approval for the and Patient has previously had a Special Authority approval for the and Patient has previously had a Special Authority approval for the and Patient has previously had a Special Authority approval for the and Patient has previously had a Special Authority approval for the and Patient has previously had a Special Authority approval for the and Patient has previously had a Special Authority approval for the and Patient has previously had a Special Authority approval for the and Patient has previously had a Special Authority approval for the and Patient has previously had a Special Authority approval for the and Patient has previously had a Special Authority approval for the and Patient has previously had a Special Authority approval for the and Patient has previously had a Special Authority approval for the and Patient has previously had a Special Authority approval for the and Patient has previously had a Special Authority approval fo		

May 2025

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:	Name:
Ward:	. NHI:
Adalimumab (Humira - Alternative brand) - continued	
CONTINUATION – Psoriasis - severe chronic plaque Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a dermatologist or Practitioner or guideline that has been endorsed by the Health NZ Hospital. and	on the recommendation of a dermatologist, or in accordance with a protocol
Patient had "whole body" severe chronic plaque	psoriasis at the start of treatment
or or is sustained at this level, when or	nt course the patient has a PASI score which is reduced by 75% or ompared with the pre-adalimumab treatment baseline value
Following each prior adalimumab treatme improvement of 5 or more, when compare	nt course the patient has a Dermatology Quality of Life Index (DLQI) and with the pre-treatment baseline value
or	
Patient had severe chronic plaque psoriasis of the and	ne face, or palm of a hand or sole of a foot at the start of treatment
	nt course the patient has a reduction in the PASI symptom subscores ig, to slight or better, or sustained at this level, as compared to the
	nt course the patient has a reduction of 75% or more in the skin area pared to the pre-adalimumab treatment baseline value
and O Adalimumab to be administered at doses no greater than 40	mg every 14 days
INITIATION – Pyoderma gangrenosum Re-assessment required after 6 months	
Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a dermatologist, or in accordant Hospital.	nce with a protocol or guideline that has been endorsed by the Health NZ
O The patient has experienced intolerable side effects fr	om adalimumab (Amgevita) following a minimum of 4 weeks treatment
	ontrol following a minimum of 4 weeks treatment with adalimumab response to a change in treatment regimen
and O Patient has received a maximum of 6 months treatment with	Amgevita
O Patient has previously had a Special Authority approval for t	he Humira brand of adalimumab for this indication
A maximum of 8 doses	

I confirm that the above details are correct:

May 2025

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:		
ne: Name:			
Vard:NHI:			
Adalimumab (Humira - Alternative brand) - continued			
CONTINUATION – Pyoderma gangrenosum Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)			
Prescribed by, or recommended by a dermatologist, or in accordance Hospital.	ee with a protocol or guideline that has been endorsed by the Health NZ		
The patient has demonstrated clinical improvement and continuand	nues to require treatment		
A maximum of 8 doses			
INITIATION – Crohn's disease - adult Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)			
Prescribed by, or recommended by a gastroenterologist or Practition protocol or guideline that has been endorsed by the Health NZ Hosp and	ner on the recommendation of a gastroenterologist, or in accordance with a bital.		
or Patient has developed symptoms of loss of disease con 6 months treatment with Amgevita and clinician attribute	trol following a minimum of 4 weeks treatment, and a maximum of es this loss of disease response to a change in treatment regimen sease destabilisation if there were to be a change to current treatment		
Patient has previously had a Special Authority approval for the and Adalimumab to be administered at doses no greater than 40 n			
CONTINUATION – Crohn's disease - adult Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)			
Prescribed by, or recommended by a gastroenterologist or Practition protocol or guideline that has been endorsed by the Health NZ Hosp and	ner on the recommendation of a gastroenterologist, or in accordance with a pital.		
O CDAI score has reduced by 100 points from the CDAI soor O CDAI score is 150 or less or O The patient has demonstrated an adequate response to			
Adalimumab to be administered at doses no greater than 40 m	ng every 14 days		

I confirm that the above details are correct:

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

May 2025

PRES	CRII	BER		PATIENT:
Name	ıme:			
Ward:	Vard:NHI:			
Adal	imu	mak	(Hu	mira - Alternative brand) - continued
Re-a	sses	smen	t requ	's disease - children ired after 6 months oxes where appropriate)
and				by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.
		or	OOO	The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen Patient has Crohn's and is considered to be at risk of disease destabilisation if there were to be a change to current treatment
	and	\circ		nt has previously had a Special Authority approval for the Humira brand of adalimumab for this indication mumab to be administered at doses no greater than 40 mg every 14 days
Re-a	sses:	Preso proto or or	t requ (tick b cribed	by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital. PCDAI score has reduced by 10 points from the PCDAI score when the patient was initiated on adalimumab PCDAI score is 15 or less The patient has demonstrated an adequate response to treatment, but PCDAI score cannot be assessed
	and	0	Adali	mumab to be administered at doses no greater than 40 mg every 14 days
Re-a	ssess equis	smen sites Preso	t requ (tick b cribed	's disease - fistulising ired after 6 months oxes where appropriate) by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.
	and	or or	O O	The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen Patient has Crohn's and is considered to be at risk of disease destabilisation if there were to be a change to current treatment on the previously had a Special Authority approval for the Humira brand of adalimumab for this indication
	and	0		mumab to be administered at doses no greater than 40 mg every 14 days

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

May 2025

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Adalimumab (Humira - Alternativ	e brand) - continued
There has been a management score, to	draining fistulae have decreased from baseline by at least 50% arked reduction in drainage of all fistula(e) from baseline as demonstrated by a reduction in the Fistula orgether with less induration and patient-reported pain tered at doses no greater than 40 mg every 14 days
INITIATION – Ocular inflammation – chr Re-assessment required after 12 months Prerequisites (tick boxes where appropria	te)
NZ Hospital.	by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
and a maximum of 6 Patient has developed maximum of 6 mont regimen or Patient has uveitis at and Patient has previously had and	erienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, months treatment with Amgevita and symptoms of loss of disease control following a minimum of 4 weeks treatment with Amgevita, and a she treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment and is considered to be at risk of vision loss if they were to change treatment a Special Authority approval for the Humira brand of adalimumab for this indication tered at doses no greater than 40 mg every 14 days
CONTINUATION – Ocular inflammation	- chronic
Re-assessment required after 12 months Prerequisites (tick boxes where appropria	te)
	by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
or Following each 12-m Uveitis Nomenclature resolution of uveitic or Following each 12-m	a good clinical response following 12 weeks' initial treatment onth treatment period, the patient has had a sustained reduction in inflammation (Standardisation of e (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or systoid macular oedema) onth treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone eroid drops less than twice daily if under 18 years old
Adalimumab to be adminis	tered at doses no greater than 40 mg every 14 days

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:	Name:
Ward:	NHI:
Adalimumab (Humira - Alternative brand) - con	ntinued
INITIATION – Ocular inflammation – severe Re-assessment required after 12 months	
Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by any relevant p NZ Hospital.	ractitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
and a maximum of 6 months treatmer	
	oss of disease control following a minimum of 4 weeks treatment with Amgevita, and a Amgevita and clinician attributes this loss of disease response to a change in treatment
O Patient has uveitis and is considered to	to be at risk of vision loss if they were to change treatment
Adalimumab to be administered at doses no	ity approval for the Humira brand of adalimumab for this indication o greater than 40 mg every 14 days
CONTINUATION – Ocular inflammation – severe Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by any relevant p NZ Hospital.	ractitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
O The patient has had a good clinical re	sponse following 3 initial doses
	eriod, the patient has had a sustained reduction in inflammation (Standardisation of $\frac{1}{2}$ + anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or edema)
	eriod, the patient has a sustained steroid sparing effect, allowing reduction in prednisone than twice daily if under 18 years old
Adalimumab to be administered at doses no	o greater than 40 mg every 14 days

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	CRIBER PATIENT:
Name	:
Ward	NHI:
Adal	mumab (Humira - Alternative brand) - continued
Re-a	ATION – ankylosing spondylitis seessment required after 6 months equisites (tick boxes where appropriate) Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment or Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) Patient has received a maximum of 6 months treatment with Amgevita Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication Adalimumab to be administered at doses no greater than 40 mg every 14 days
Re-a	TINUATION – ankylosing spondylitis seessment required after 6 months equisites (tick boxes where appropriate) Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. Treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10 point scale, or an improvement in BASDAI of 50%, whichever is less and Adalimumab to be administered at doses no greater than 40 mg every 14 days
Re-a	ATION – Arthritis – oligoarticular course juvenile idiopathic seessment required after 6 months equisites (tick boxes where appropriate) Prescribed by, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	Or The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment O Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen Patient has received a maximum of 6 months treatment with Amgevita Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

May 2025

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Adalimumab (Humira - Alternative brand) - continued	
CONTINUATION – Arthritis – oligoarticular course juvenile idiopathic Re-assessment required after 6 months Prerequisites (tick box where appropriate)	
by the Health NZ Hospital.	ogist, or in accordance with a protocol or guideline that has been endorsed
For patients that demonstrate at least a continuing 30% improvement assessment from baseline	nt in active joint count and continued improvement in physician's global
INITIATION – Arthritis - polyarticular course juvenile idiopathic Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by a named specialist or rheumatol by the Health NZ Hospital. and	ogist, or in accordance with a protocol or guideline that has been endorsed
i i i i i i i i i i i i i i i i i i i	n adalimumab (Amgevita) following a minimum of 4 weeks treatment
O Patient has developed symptoms of loss of disease con (Amgevita) and clinician attributes this loss of disease re	trol following a minimum of 4 weeks treatment with adalimumab esponse to a change in treatment regimen
Patient has received a maximum of 6 months treatment with A	amgevita
Patient has previously had a Special Authority approval for the	Humira brand of adalimumab for this indication
CONTINUATION – Arthritis - polyarticular course juvenile idiopathic	
Re-assessment required after 6 months	
Prerequisites (tick box where appropriate)	
by the Health NZ Hospital.	ogist, or in accordance with a protocol or guideline that has been endorsed
For patients that demonstrate at least a continuing 30% improvement assessment from baseline	nt in active joint count and continued improvement in physician's global
INITIATION – Arthritis - psoriatic Re-assessment required after 6 months	
Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by a named specialist or rheumatol by the Health NZ Hospital.	ogist, or in accordance with a protocol or guideline that has been endorsed
	m adalimumab (Amgevita) following a minimum of 4 weeks treatment
Patient has developed symptoms of loss of disease con (Amgevita) and clinician attributes this loss of disease re	trol following a minimum of 4 weeks treatment with adalimumab
and	Spondo to a change in acadinon regimen
O Patient has received a maximum of 6 months treatment with A and	umgevita
Patient has previously had a Special Authority approval for the	Humira brand of adalimumab for this indication
Adalimumab to be administered at doses no greater than 40 r	ng every 14 days

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	PRESCRIBER PATIENT:			PATIENT:	
Name	lame:			Name:	
Ward:	/ard:NHI:				NHI:
Adal	imu	mak	(Hu	mira - Alternative brand) - continued	
Re-a	ssess siups l	smen sites Preso	t requ (tick b cribed	rthritis - psoriatic ired after 6 months oxes where appropriate) by, or recommended by a named specialist or rheumatol th NZ Hospital.	ogist, or in accordance with a protocol or guideline that has been endorsed
	and	0	respo	patient demonstrates at least a continuing 30% improvements to prior adalimumab treatment in the opinion of the temperature to be administered at doses no greater than 40 necessity.	
Re-a	ssess equis	smen sites Preso	t requ (tick b cribed	tis – rheumatoid ired after 6 months oxes where appropriate) by, or recommended by a rheumatologist or Practitioner guideline that has been endorsed by the Health NZ Hosp	on the recommendation of a rheumatologist, or in accordance with a bital.
anu		or	O O		trol following a minimum of 4 weeks treatment with adalimumab esponse to a change in treatment regimen
	and and and	O O		nt has received a maximum of 6 months treatment with A	
	anu	or	O O	Adalimumab to be administered at doses no greater that Patient cannot take concomitant methotrexate and require an adequate response	n 40 mg every 14 days res doses of adalimumab higher than 40 mg every 14 days to maintain
Re-a	ssess equis	smen sites Preso	t requ (tick b cribed	arthritis – rheumatoid ired after 6 months oxes where appropriate) by, or recommended by a rheumatologist or Practitioner guideline that has been endorsed by the Health NZ Hosp	on the recommendation of a rheumatologist, or in accordance with a bital.
and	and	0		patient demonstrates at least a continuing 30% improvemonse to prior adalimumab treatment in the opinion of the t	nent in active joint count from baseline and a clinically significant reating physician
		or	0		n 40 mg every 14 days ires doses of adalimumab higher than 40 mg every 14 days to maintain
				an adequate response	

PRESCR	RIBER	PATIENT:
Name: .		Name:
Ward:		NHI:
Adalim	umab (Humira - Alternative brand) - continued	
	ON – Still's disease – adult-onset (AOSD) essment required after 6 months	
Prerequ	tisites (tick boxes where appropriate)	
O and	Prescribed by, or recommended by a rheumatologist or Practitioner protocol or guideline that has been endorsed by the Health NZ Hosp	on the recommendation of a rheumatologist, or in accordance with a pital.
	or	m adalimumab (Amgevita) following a minimum of 4 weeks treatment trol following a minimum of 4 weeks treatment with adalimumab esponse to a change in treatment regimen
ar	O Patient has received a maximum of 6 months treatment with A	
Re-asse	IUATION – Still's disease – adult-onset (AOSD) essment required after 6 months uisites (tick box where appropriate)	
and	Prescribed by, or recommended by a rheumatologist or Practitioner protocol or guideline that has been endorsed by the Health NZ Hosp	on the recommendation of a rheumatologist, or in accordance with a oital.
O	The patient has demonstrated a sustained improvement in inflamma	atory markers and functional status

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Oigilica.	 Duic.	

PRES	SCR	IBER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Abci	ixir	nab		
INITI Prer			(tick boxes where appropriate)	
		0	For use in patients with acute coronary syndromes undergoing	g percutaneous coronary intervention
	or	0	For use in patients undergoing intra-cranial intervention	

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Signed.	Date:	
Oigilica.	 Duic.	

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

SCRIBER	PATIENT:
ne:	
d:	NHI:
olumab	
requisites O Pres	nt required after 4 months s (tick boxes where appropriate) scribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health I
and	Patient has metastatic or unresectable melanoma (excluding uveal) stage III or IV Baseline measurement of overall tumour burden is documented clinically and radiologically
and	The patient has ECOG performance score of 0-2
OI	Patient has not received funded pembrolizumab
	Patient has received an initial Special Authority approval for pembrolizumab and has discontinued pembrolizumab within 12 weeks of starting treatment due to intolerance and The cancer did not progress while the patient was on pembrolizumab
and	Documentation confirming that the patient has been informed and acknowledges that funded treatment with nivolumab will not be continued if their disease progresses
NTINUATION assessme requisites	Documentation confirming that the patient has been informed and acknowledges that funded treatment with nivolumab will not be continued if their disease progresses ON – less than 24 months on treatment nt required after 4 months (tick boxes where appropriate)
NTINUATION assessme requisites O Pres Hosp	Documentation confirming that the patient has been informed and acknowledges that funded treatment with nivolumab will not be continued if their disease progresses ON – less than 24 months on treatment nt required after 4 months (itick boxes where appropriate) scribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health pital. O Patient's disease has had a complete response to treatment or Patient's disease has had a partial response to treatment or Patient's disease has had a partial response to treatment
NTINUATION assessment requisites O Presented Hospitalian	Documentation confirming that the patient has been informed and acknowledges that funded treatment with nivolumab will not be continued if their disease progresses ON – less than 24 months on treatment nt required after 4 months (tick boxes where appropriate) scribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health pital. O Patient's disease has had a complete response to treatment O Patient's disease has had a partial response to treatment
NTINUATION assessme requisites Hospital are	Documentation confirming that the patient has been informed and acknowledges that funded treatment with nivolumab will not be continued if their disease progresses ON – less than 24 months on treatment nt required after 4 months is (tick boxes where appropriate) scribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health pital. O Patient's disease has had a complete response to treatment or O Patient's disease has had a partial response to treatment or O Patient has stable disease Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period The treatment remains clinically appropriate and the patient is benefitting from the treatment Patient has previously discontinued treatment with nivolumab for reasons other than severe toxicity or disease progression

Ward: Nivolumab - continued CONTINUATION - more than 24 m Re-assessment required after 4 mor Prerequisites (tick boxes where app	oths
Nivolumab - continued CONTINUATION - more than 24 m Re-assessment required after 4 mor Prerequisites (tick boxes where app Prescribed by, or recomme Hospital.	onths on treatment ths propriate)
CONTINUATION – more than 24 m Re-assessment required after 4 mor Prerequisites (tick boxes where app Prescribed by, or recomme Hospital.	oropriate)
Re-assessment required after 4 mor Prerequisites (tick boxes where app O Prescribed by, or recomme Hospital.	oropriate)
Hospital.	ended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
l _	treatment for more than 24 months
and Patient has been on treatment for more than 24 months Or Patient's disease has had a complete response to treatment or Patient has stable disease and Response to treatment in target lesions has been determined by comparable radiologic or clinical assessment follor the most recent treatment period The treatment remains clinically appropriate and the patient is benefitting from the treatment or Patient has previously discontinued treatment with nivolumab for reasons other than severe toxicity or disease progression and Patient has signs of disease progression and Disease has not progressed during previous treatment with nivolumab	

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- 3	Ziuneu.	Date:	
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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	ESCRIBER PATIENT:			
Name: Name:				
Ward:	Vard:NHI:			
Nivolumab	- continued			
INITIATION - I	renal cell carcinoma, first line It required after 4 months (tick boxes where appropriate) Patient is currently on treatment with nivolumab and met all remaining criteria prior to commencing treatment The patient has metastatic renal cell carcinoma The patient has set streatment naive The patient has ECOG performance status 0-2 The patient has sercomatoid histology The patient has sarcomatoid histology Or Haemoglobin levels less than the lower limit of normal Or Corrected serum calcium level greater than 10 mg/dL (2.5 mmol/L) Or Neutrophils greater than the upper limit of normal Or Platelets greater than the upper limit of normal Or Interval of less than 1 year from original diagnosis to the start of systemic therapy Or Karnofsky performance score of less than or equal to 70 Nivolumab is to be used in combination with ipilimumab for the first four treatment cycles at a maximum dose of 3 mg/kg			
	O Nivolumab is to be used at a maximum maintenance dose of 240 mg every 2 weeks (or equivalent)			
Re-assessmer	renal cell carcinoma, second line at required after 4 months (tick boxes where appropriate)			
and and	Patient has metastatic renal-cell carcinoma The disease is of predominant clear-cell histology Patient has ECOG performance status 0-2			
and and and	Patient has documented disease progression following one or two previous regimens of antiangiogenic therapy Patient has not previously received a funded immune checkpoint inhibitor			
	Nivolumab is to be used as monotherapy at a maximum dose of 240 mg every 2 weeks (or equivalent) and discontinued at disease progression			

PRES	CRIB	ER			PATIENT:
Name	e:				Name:
Ward:	:				NHI:
Nivo	luma	ıb -	conti	inued	
Re-a	ssess	men	t requ	enal cell carcinoma ired after 4 months poxes where appropriate)	
		or or	O O O	Patient's disease has had a complete response to treatment. Patient's disease has had a partial response to treatment. Patient has stable disease	
	and (and))	Nivol	vidence of disease progression umab is to be used as monotherapy at a maximum dose ression	of 240 mg every 2 weeks (or equivalent) and discontinued at disease

I confirm that the above details are correct:	
Signed:	Date:

RS2056 - Pembrolizumab

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	MSI-H/dMMR advanced colorectal cancer - INITIATION	436
	MSI-H/dMMR advanced colorectal cancer - CONTINUATION	437
	Urothelial carcinoma - INITIATION	437
	Urothelial carcinoma - CONTINUATION	437
	Breast cancer, advanced - INITIATION	434
	Breast cancer, advanced - CONTINUATION	
	Head and neck squamous cell carcinoma - INITIATION	435
	Head and neck squamous cell carcinoma - CONTINUATION	436
	Non-small cell lung cancer first-line combination therapy - INITIATION	
	Non-small cell lung cancer first-line combination therapy - CONTINUATION	434
	Non-small cell lung cancer first-line monotherapy - INITIATION	432
	Non-small cell lung cancer first-line monotherapy - CONTINUATION	433
	Relapsed/refractory Hodgkin lymphoma - INITIATION	438
	Relapsed/refractory Hodgkin lymphoma - CONTINUATION	438
	Unresectable or metastatic melanoma - INITIATION	430
	Unresectable or metastatic melanoma, less than 24 months on treatment - CONTINUATION	430
	Unresectable or metastatic melanoma, more than 24 months on treatment - CONTINUATION	431
ı		

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

CRIBER	PATIENT:	
:	Name:	
Vard: NHI:		
brolizu	ımab	
	unresectable or metastatic melanoma	
	ent required after 4 months s (tick boxes where appropriate)	
$\overline{}$		
	scribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health spital.	
O	Patient has metastatic or unresectable melanoma (excluding uveal) stage III or IV	
and	Baseline measurement of overall tumour burden is documented clinically and radiologically	
and and	The patient has ECOG performance score of 0-2	
	O Patient has not received funded nivolumab	
0	Patient has received an initial Special Authority approval for nivolumab and has discontinued nivolumab within 12 weeks	
	of starting treatment due to intolerance	
	The cancer did not progress while the patient was on nivolumab	
and		
TINUATI	Documentation confirming that the patient has been informed and acknowledges that funded treatment with pembrolizumab will not be continued if their disease progresses ION – unresectable or metastatic melanoma, less than 24 months on treatment ent required after 4 months s (tick boxes where appropriate)	
TINUATI ssessme equisites Pres	Documentation confirming that the patient has been informed and acknowledges that funded treatment with pembrolizumab will not be continued if their disease progresses ION – unresectable or metastatic melanoma, less than 24 months on treatment ent required after 4 months s (tick boxes where appropriate)	
TINUATI ssessme equisites Pres	Documentation confirming that the patient has been informed and acknowledges that funded treatment with pembrolizumab will not be continued if their disease progresses ION – unresectable or metastatic melanoma, less than 24 months on treatment ent required after 4 months is (tick boxes where appropriate) scribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Healt spital.	
TINUATI ssessme equisites Pres	Documentation confirming that the patient has been informed and acknowledges that funded treatment with pembrolizumab will not be continued if their disease progresses ION – unresectable or metastatic melanoma, less than 24 months on treatment ent required after 4 months is (tick boxes where appropriate) scribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Healt spital. O Patient's disease has had a complete response to treatment or	
TINUATI ssessme equisites Pres	Documentation confirming that the patient has been informed and acknowledges that funded treatment with pembrolizumab will not be continued if their disease progresses ION – unresectable or metastatic melanoma, less than 24 months on treatment ent required after 4 months s (tick boxes where appropriate) scribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Healt epital. O Patient's disease has had a complete response to treatment O Patient's disease has had a partial response to treatment	
TINUATI ssessme equisites Pres	Documentation confirming that the patient has been informed and acknowledges that funded treatment with pembrolizumab will not be continued if their disease progresses ION – unresectable or metastatic melanoma, less than 24 months on treatment ent required after 4 months is (tick boxes where appropriate) scribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Healt spital. O Patient's disease has had a complete response to treatment or	
TINUATI ssessme equisites Pres Hos	Documentation confirming that the patient has been informed and acknowledges that funded treatment with pembrolizumab will not be continued if their disease progresses ION – unresectable or metastatic melanoma, less than 24 months on treatment ent required after 4 months is (tick boxes where appropriate) Secribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Healt spital. O Patient's disease has had a complete response to treatment or O Patient's disease has had a partial response to treatment or O Patient has stable disease	
TINUATI ssessme equisites Pres Hos	Documentation confirming that the patient has been informed and acknowledges that funded treatment with pembrolizumab will not be continued if their disease progresses ON - unresectable or metastatic melanoma, less than 24 months on treatment ent required after 4 months is (tick boxes where appropriate) Secribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Healt spital. O	
TINUATI ssessme equisites Pres Hos	Documentation confirming that the patient has been informed and acknowledges that funded treatment with pembrolizumab will not be continued if their disease progresses ION – unresectable or metastatic melanoma, less than 24 months on treatment ent required after 4 months is (tick boxes where appropriate) Scribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Healt epital. O Patient's disease has had a complete response to treatment or O Patient's disease has had a partial response to treatment or O Patient has stable disease Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period ind	
TINUATI ssessme equisites Hos	Documentation confirming that the patient has been informed and acknowledges that funded treatment with pembrolizumab will not be continued if their disease progresses ON - unresectable or metastatic melanoma, less than 24 months on treatment entrequired after 4 months is (tick boxes where appropriate) Secribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Healt spital. O	
TINUATI ssessme equisites Pres Hos	Documentation confirming that the patient has been informed and acknowledges that funded treatment with pembrolizumab will not be continued if their disease progresses ION – unresectable or metastatic melanoma, less than 24 months on treatment ent required after 4 months is (tick boxes where appropriate) scribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health spital. O Patient's disease has had a complete response to treatment or O Patient's disease has had a partial response to treatment or O Patient has stable disease Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period The treatment remains clinically appropriate and the patient is benefitting from the treatment	
TINUATI ssessme equisites Hos	Documentation confirming that the patient has been informed and acknowledges that funded treatment with pembrolizumab will not be continued if their disease progresses ION – unresectable or metastatic melanoma, less than 24 months on treatment ent required after 4 months is (tick boxes where appropriate) scribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Healt spital. O Patient's disease has had a complete response to treatment or O Patient's disease has had a partial response to treatment or O Patient has stable disease Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period The treatment remains clinically appropriate and the patient is benefitting from the treatment	
TINUATI ssessme equisites Hos	Documentation confirming that the patient has been informed and acknowledges that funded treatment with pembrolizumab will not be continued if their disease progresses ION – unresectable or metastatic melanoma, less than 24 months on treatment after equired after 4 months is (tick boxes where appropriate) scribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Healt spital. O Patient's disease has had a complete response to treatment or Patient has stable disease Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period The treatment remains clinically appropriate and the patient is benefitting from the treatment Patient has previously discontinued treatment with pembrolizumab for reasons other than severe toxicity or disease progression Patient has signs of disease progression	
TINUATI ssessme equisites Hos	Documentation confirming that the patient has been informed and acknowledges that funded treatment with pembrolizumab will not be continued if their disease progresses ION – unresectable or metastatic melanoma, less than 24 months on treatment after equired after 4 months is (tick boxes where appropriate) scribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health spital. O Patient's disease has had a complete response to treatment or Patient has stable disease Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period The treatment remains clinically appropriate and the patient is benefitting from the treatment Patient has previously discontinued treatment with pembrolizumab for reasons other than severe toxicity or disease progression and Patient has previously discontinued treatment with pembrolizumab for reasons other than severe toxicity or disease progression	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pembrolizumab - continued	
CONTINUATION – unresectable or metastatic melanoma, more than 24 in Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	months on treatment
O Prescribed by, or recommended by a medical oncologist, or in acconduction Hospital.	rdance with a protocol or guideline that has been endorsed by the Health NZ
Patient has been on treatment for more than 24 months and	
O Patient's disease has had a complete respons or O Patient's disease has had a partial respons or O Patient has stable disease	
the most recent treatment period and The treatment remains clinically appropriate and	determined by comparable radiologic or clinical assessment following the patient is benefitting from the treatment
progression and Patient has signs of disease progression and	h pembrolizumab for reasons other than severe toxicity or disease
O Disease has not progressed during previous treat	tment with pembrolizumab

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Signed.	Date:	
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PRESCRIBEI	٦	PATIENT:			
Name:		Name:			
Ward: NHI:					
Pembrolizu	embrolizumab - continued				
Re-assessme	non-small cell lung cancer first-line monotherapy ent required after 4 months s (tick boxes where appropriate)				
	O Prescribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
and and and and	Pembrolizumab to be used as monotherapy There is documentation confirming the disease express validated test unless not possible to ascertain There is documentation confirming the disease expression There is documentation confirming the disease expression by a validated test unless not possible to ascertain	iative setting ne checkpoint inhibitor for NSCLC tion confirming that the disease does not express activating mutations of es PD-L1 at a level greater than or equal to 50% as determined by a expresses PD-L1 at a level greater than or equal to 1% as determined			
and and and	Patient has an ECOG 0-2 Pembrolizumab to be used at a maximum dose of 200 mg even Baseline measurement of overall tumour burden is documented.				

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:	Name:
Ward:	NHI:
Pembrolizu	mab - continued
Prerequisites Pres	ON – non-small cell lung cancer first-line monotherapy nt required after 4 months (tick boxes where appropriate) cribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in redance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
or	Patient's disease has had a complete response to treatment Patient's disease has had a partial response to treatment Patient has stable disease
and and and and and and and	Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period No evidence of disease progression The treatment remains clinically appropriate and patient is benefitting from treatment Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent) Treatment with pembrolizumab to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks)
Prerequisites Pres	non-small cell lung cancer first-line combination therapy Intrequired after 4 months (tick boxes where appropriate) cribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in redance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
and	Patient has locally advanced or metastatic, unresectable, non-small cell lung cancer The patient has not had chemotherapy for their disease in the palliative setting Patient has not received prior funded treatment with an immune checkpoint inhibitor for NSCLC For patients with non-squamous histology there is documentation confirming that the disease does not express activating mutations of EGFR or ALK tyrosine kinase unless not possible to ascertain Pembrolizumab to be used in combination with platinum-based chemotherapy Patient has an ECOG 0-2 Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent) for a maximum of 16 weeks Baseline measurement of overall tumour burden is documented clinically and radiologically

I confirm that the above details are correct:

Signed: Date:

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PATIENT:	
Name:	
NHI:	
relevant practitioner on the recommendation of a medical oncologist, or in by the Health NZ Hospital.	
eatment ment med by comparable radiologic assessment following the most recent benefitting from treatment every three weeks (or equivalent) ion of 24 months from commencement (or equivalent of 35 cycles dosed	
elevant practitioner on the recommendation of a relevant specialist, or in by the Health NZ Hospital.	
met all remaining criteria prior to commencing treatment	
n, inoperable locally advanced triple-negative breast cancer (that does not uding FISH or other technology]) ple-negative breast cancer (that does not express ER, PR or HER2 IHC3+ positive Score (CPS) is greater than or equal to 10 e palliative setting demotherapy documented clinically and radiologically if 200 mg every three weeks (or equivalent) for a maximum of 16 weeks	

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:
Pembrolizu	mab - continued
CONTINUATION Re-assessmer Prerequisites O Pres	DN – breast cancer, advanced to required after 6 months (tick boxes where appropriate) cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ospital. Patient's disease has had a complete response to treatment Patient's disease has had a partial response to treatment Patient has stable disease No evidence of disease progression Response to treatment in target lesions has been determined by a comparable radiologic assessment following the most recent treatment period Pembrolizumab is to be used at a maximum dose of 200 mg every three weeks (or equivalent) Treatment with pembrolizumab is to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed
Re-assessmer Prerequisites Pres	head and neck squamous cell carcinoma It required after 4 months (tick boxes where appropriate) cribed by, or recommended by a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in redance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
and O or an an an an	Patient is currently on treatment with pembrolizumab and met all remaining criteria prior to commencing treatment Patient has recurrent or metastatic head and neck squamous cell carcinoma of mucosal origin (excluding nasopharyngeal carcinoma) that is incurable by local therapies Patient has not received prior systemic therapy in the recurrent or metastatic setting Patient has a positive PD-L1 combined positive score (CPS) of greater than or equal to 1 Patient has an ECOG performance score of 0-2 Pembrolizumab to be used in combination with platinum-based chemotherapy Pembrolizumab to be used as monotherapy

I confirm that the above details are correct:

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Signed.	Date.
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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	e:			
Ward	:			NHI:
Pem	broli	zun	nab	- continued
Re-a	ssessi equisi P	men i tes resc	t requ (tick b	ead and neck squamous cell carcinoma ired after 4 months oxes where appropriate) by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health I. Patient's disease has had a complete response to treatment
			\circ	Patient's disease has had a partial response to treatment
		or	0	Patient has stable disease
	and and and)))	Pemb Treat	orolizumab is to be used at a maximum dose of 200 mg every three weeks (or equivalent) ment with pembrolizumab is to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed 3 weeks)
Re-a	ssessi equisi	men i tes resc	t requ (tick b cribed	dMMR advanced colorectal cancer ired after 4 months oxes where appropriate) by, or recommended by a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	Or (С	Patie	nt is currently on treatment with pembrolizumab and met all remaining criteria prior to commencing treatment
	or	and and and and		Patient has deficient mismatch repair (dMMR) or microsatellite instability-high (MSI-H) metastatic colorectal cancer Patient has deficient mismatch repair (dMMR) or microsatellite instability-high (MSI-H) unresectable colorectal cancer Patient is treated with palliative intent Patient has not previously received funded treatment with pembrolizumab Patient has an ECOG performance score of 0-2 Baseline measurement of overall tumour burden is documented clinically and radiologically Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent) for a maximum of 16 weeks

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

May 2025

PRESCR	RIBER	PATIENT:
Name: .		
Ward:		NHI:
Pembro	olizuı	mab - continued
Re-asse	Preson NZ H	ON – MSI-H/dMMR advanced colorectal cancer not required after 4 months (tick boxes where appropriate) cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health Hospital. No evidence of disease progression Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent) Treatment with pembrolizumab is to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks)
Re-asse	ssmer	Urothelial carcinoma nt required after 4 months (tick boxes where appropriate)
and _	Preso	cribed by, or recommended by a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in rdance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
or	0	Patient is currently on treatment with pembrolizumab and met all remaining criteria prior to commencing treatment
	an an	O Patient has an ECOG performance score of 0-2 O Patient has documented disease progression following treatment with chemotherapy
Re-asse	essmer uisites Prese	ON – Urothelial carcinoma Interceptive after 4 months (tick boxes where appropriate) cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health Hospital.
and ar ar	or or or or	O Patient's disease has had a complete response to treatment O Patient's disease has had a partial response to treatment
		every 3 weeks)

PRESCRIB	ER	PATIENT:
		Name:
		NHI:
INITIATION Re-assessi Prerequisi	Patient is currently on treatment with pembrolizumab and met Patient is currently on treatment with pembrolizumab and met Patient has relapsed/refractory Hodgkin lymand Patient is ineligible for autologous stem cell or	all remaining criteria prior to commencing treatment uphoma after two or more lines of chemotherapy transplant a and has previously undergone an autologous stem cell transplant
Re-assessi Prerequisi	Patient has received a partial or complete response to pembro	ccordance with a protocol or guideline that has been endorsed by the Health blizumab n of 24 months from commencement (or equivalent of 35 cycles dosed

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PRESCRIBER			PATIENT:
Name:			
Ward:			NHI:
Durva	lum	ab	
Re-ass	essn	nent	ion-small cell lung cancer i required after 4 months (tick boxes where appropriate)
		or	Patient has histologically or cytologically documented stage III, locally advanced, unresectable non-small cell lung cancer (NSCLC) Patient has histologically or cytologically documented stage IIb (T1N2a only), locally advanced, unresectable non-small cell lung cancer (NSCLC)
	and and	C	Patient has received two or more cycles of platinum-based chemotherapy concurrently with definitive radiation therapy Patient has no disease progression following the second or subsequent cycle of platinum-based chemotherapy with definitive radiation therapy treatment
ar	and and and)	Patient has a ECOG performance status of 0 or 1 Patient has completed last radiation dose within 8 weeks of starting treatment with durvalumab Patient must not have received prior PD-1 or PD-L1 inhibitor therapy for this condition
	ind	or	O Durvalumab is to be used at a maximum dose of no greater than 10 mg/kg every 2 weeks O Durvalumab is to be used at a flat dose of 1500 mg every 4 weeks
а	nd)	Treatment with durvalumab to cease upon signs of disease progression
Re-ass	essn	nent	N – Non-small cell lung cancer t required after 4 months (tick boxes where appropriate)
a	nd)	The treatment remains clinically appropriate and the patient is benefitting from treatment
		or	O Durvalumab is to be used at a maximum dose of no greater than 10 mg/kg every 2 weeks O Durvalumab is to be used at a flat dose of 1500 mg every 4 weeks
	and (_	Treatment with durvalumab to cease upon signs of disease progression Total continuous treatment duration must not exceed 12 months
)	Total continuous treatment duration must not exceed 12 months

I confirm that the above details are correct:	
Signed:	Date:

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	CRIBER	PATIENT:
Name:		Name:
Ward:		NHI:
Atezo	lizuma	ıb
Re-as	sessmen	non-small cell lung cancer second line monotherapy at required after 4 months (tick boxes where appropriate)
and) Preso	cribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in redance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
	and	Patient has locally advanced or metastatic non-small cell lung cancer
	and	Patient has not received prior funded treatment with an immune checkpoint inhibitor for NSCLC
	and	For patients with non-squamous histology there is documentation confirming that the disease does not express activating mutations of EGFR or ALK tyrosine kinase unless not possible to ascertain
	and	Patient has an ECOG 0-2
	and	Patient has documented disease progression following treatment with at least two cycles of platinum-based chemotherapy
	and	Atezolizumab is to be used as monotherapy at a dose of 1200 mg every three weeks (or equivalent) for a maximum of 16 weeks
		Baseline measurement of overall tumour burden is documented clinically and radiologically
CONI	INITATIO	ON – non-small cell lung cancer second line monotherapy
Re-as	sessmen	t required after 4 months
and	Preso	(tick boxes where appropriate) cribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in redance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
		O Patient's disease has had a complete response to treatment
	or	O Patient's disease has had a partial response to treatment
	or	O Patient has stable disease
	and	Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period
	and	No evidence of disease progression
	and	The treatment remains clinically appropriate and patient is benefitting from treatment
	and	Atezolizumab to be used at a maximum dose of 1200 mg every three weeks (or equivalent)
	and O	Treatment with atezolizumab to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks)

I confirm that the above details are correct:

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Siurieu.	 Date.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Atezolizumab - continued	
INITIATION – unresectable hepatocellular carcinoma Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Patient is currently on treatment with atezolizumab and met all or Patient has locally advanced or metastatic, unresectable and Patient has preserved liver function (Child-Pugh A) and Transarterial chemoembolisation (TACE) is unsuitable and Patient has not received prior systemic therapy for Or Patient received funded lenvatinib before 1 March or Patient has experienced treatment-limiting to and No disease progression since initiation of le	e hepatocellular carcinoma r the treatment of hepatocellular carcinoma 2025 oxicity from treatment with lenvatinib
Patient has an ECOG performance status of 0-2 and To be given in combination with bevacizumab CONTINUATION – unresectable hepatocellular carcinoma	
Re-assessment required after 6 months Prerequisites (tick box where appropriate)	
O No evidence of disease progression	<u></u>

I confirm that the above details are correct:

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Signed.	Date:	
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PRESCRIBER	PA	TIENT:
Name:	Na	me:
Ward:	NH	П:
Ipilimumab		
INITIATION – renal Re-assessment requ Prerequisites (tick b		
or The	patient is currently on treatment with ipilimumab and met all re	emaining criteria prior to commencing treatment
and or or or and	Haemoglobin levels less than the lower limit of normal Corrected serum calcium level greater than 10 mg/dL Neutrophils greater than the upper limit of normal Platelets greater than the upper limit of normal Interval of less than 1 year from original diagnosis to the	(2.5 mmol/L) the start of systemic therapy

Signed: Date:

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:			
Everolimus			
INITIATION Re-assessment required after 3 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a neurologist or oncologist, or in Health NZ Hospital. and O Patient has tuberous sclerosis and O Patient has progressively enlarging sub-ependymal giant cell and	accordance with a protocol or guideline that has been endorsed by the astrocytomas (SEGAs) that require treatment		
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a neurologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. Documented evidence of SEGA reduction or stabilisation by MRI within the last 3 months The treatment remains appropriate and the patient is benefiting from treatment			
Everolimus to be discontinued at progression of SEGAs INITIATION – renal cell carcinoma Re-assessment required after 4 months			
Prerequisites (tick boxes where appropriate) The patient has metastatic renal cell carcinoma and The disease is of predominant clear-cell histology and The patient has documented disease progression follow and The patient has an ECOG performance status of 0-2 and Everolimus is to be used in combination with lenvatinib or Patient has received funded treatment with nivolumab for and Patient has experienced treatment limiting toxicity from toward and There is no evidence of disease progression	or the second line treatment of metastatic renal cell carcinoma		
CONTINUATION – renal cell carcinoma Re-assessment required after 4 months Prerequisites (tick box where appropriate) There is no evidence of disease progression			
I confirm that the above details are correct:			

Signed: Date:

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

May 2025

RESCRIBER	PATIENT:
ame:	Name:
/ard:	NHI:
irolimus	
VITIATION	
Prerequisites (tick box where appropriate)	
O For rescue therapy for an organ transplant recipient lote: Rescue therapy defined as unresponsive to calcineurin inhibitor treatment due to any of the following:	reatment as defined by refractory rejection; or intolerant to calcineurin inhibitor
GFR < 30 ml/min; or	
Rapidly progressive transplant vasculopathy; or	
Rapidly progressive obstructive bronchiolitis; or	
HUS or TTP; or	
Leukoencepthalopathy; or	
Significant malignant disease	
NITIATION – severe non-malignant lymphovascular malformations e-assessment required after 6 months rerequisites (tick boxes where appropriate)	
O Patient has severe non-malignant lymphovascular malfor and	rmation*
O Malformations are not adequately controlled by scl	lerotherapy and surgery
Malformations are widespread/extensive and solar	otherapy and surgery are not considered clinically appropriate
or	
O Sirolimus is to be used to reduce malformation price	or to consideration of surgery
Patient is being treated by a specialist lymphovascular m	nalformation multi-disciplinary team
O Patient has measurable disease as defined by RECIST v	version 1.1 (see Note)
ONTINUATION – severe non-malignant lymphovascular malformate-assessment required after 12 months rerequisites (tick boxes where appropriate)	tions*
Patient's disease has had either a complete responsaccording to RECIST version 1.1 (see Note)	nse or a partial response to treatment, or patient has stable disease
O Patient's disease has stabilised or responded clinic patient notes	cally and disease response to treatment has been clearly documents in
O No evidence of progressive disease	
O The treatment remains clinically appropriate and the pati	ient is benefitting from the treatment
ote: Baseline assessment and disease responses to be assessed account (Eisenhauer et al. Eur J Cancer 2009;45:228-47)	ording to the Response Evaluation Criteria in Solid Tumours (RECIST) version

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:		
Name:	Name:		
/ard:NHI:			
Sirolimus - continued			
INITIATION – renal angiomyolipoma(s) associated with tuberous scleros	sis complex*		
Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)			
Prescribed by, or recommended by a nephrologist or urologist, or in accordance with a protocol or guideline that has been endorsed Health NZ Hospital. and			
Patient has tuberous sclerosis complex*			
C Evidence of renal angiomyolipoma(s) measuring 3 cm or greater	ater and that have shown interval growth		
CONTINUATION – renal angiomyolipoma(s) associated with tuberous series. Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	clerosis complex*		
O Documented evidence of renal angiomyolipoma reduction or	stability by magnetic resonance imaging (MRI) or ultrasound		
Demonstrated stabilisation or improvement in renal function			
The patient has not experienced angiomyolipoma haemorrha	ge or significant adverse effects to sirolimus treatment		
The treatment remains appropriate and the patient is benefitt	ing from treatment		
Note: Indications marked with * are unapproved indications			
INITIATION – refractory seizures associated with tuberous sclerosis con Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a neurologist, or in accordance Hospital.	with a protocol or guideline that has been endorsed by the Health NZ		
O Patient has epilepsy with a background of documented tuber	ous sclerosis complex*		
and			
O Vigabatrin has been trialled and has not adequat	ely controlled seizures		
Seizures are not adequately controlled by, or the treatment with at least two of the following: sodiuphenytoin sodium, and lacosamide (see Note)	patient has experienced unacceptable side effects from, optimal um valproate, topiramate, levetiracetam, carbamazepine, lamotrigine,		
O Vigabatrin is contraindicated			
Seizures are not adequately controlled by, or the	patient has experienced unacceptable side effects from, optimal ium valproate, topiramate, levetiracetam, carbamazepine, lamotrigine,		
and			
O Seizures have a significant impact on quality of life			
	opriate for this patient, or the patient has been assessed and would		
Note: Those of childbearing potential are not required to trial phenytoin sodiul required to trial sodium valproate.	ım, sodium valproate, and topiramate. Those who can father children are not		
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HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Sirolimus - continued			
CONTINUATION – refractory seizures associated with tuberous sclerosis complex* Re-assessment required after 12 months Prerequisites (tick box where appropriate)			
Prescribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
Demonstrated significant and sustained improvement in seizure rate (e.g. 50% reduction in seizure frequency) or severity and/or patient quality of life compared with baseline prior to starting sirolimus treatment Note: Indications marked with * are unapproved indications			

I confirm that the above details are correct:		
Signed:	Date:	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Bacillus calmette-guerin (BCG)	
INITIATION Prerequisites (tick box where appropriate)	
O For use in bladder cancer	

I confirm that the above details are correct:

Signed: Date:

RS2120 - Upadacitinib

Atopic dermatitis - INITIATION	449
Atopic dermatitis - CONTINUATION	450
Crohn's disease – adult - INITIATION	
Crohn's disease – adult - CONTINUATION	450
Crohn's disease – children - INITIATION	451
Crohn's disease – children - CONTINUATION	451
Rheumatoid Arthritis - CONTINUATION	449
Rheumatoid Arthritis (patients previously treated with adalimumab or etanercept) - INITIATION	449
Ulcerative colitis - INITIATION	
Ulcerative colitis - CONTINUATION	451

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	R PATIENT:	
Name:	Name:	
Ward:	NHI:	
Jpadacitinik	iib	
INITIATION - F	- Rheumatoid Arthritis (patients previously treated with adalimumab or etent required after 6 months (tick boxes where appropriate) The individual has had an initial Special Authority approval for adalimumab a The individual has experienced intolerable side effects with adalimuma	and/or etanercept for rheumatoid arthritis ab and/or etanercept
Re-assessmen	The individual is seronegative for both anti-cyclic citrullinated peptide (The individual has been started on rituximab for rheumatoid arth and The individual has experienced intolerable side effects with or At four months following the initial course of rituximab the they do not meet the renewal criteria for rheumatoid arthritical course of rituximab the they do not meet the renewal criteria for rheumatoid arthritical course of rituximab the they do not meet the renewal criteria for rheumatoid arthritical course of rituximab the they do not meet the renewal criteria for rheumatoid arthritical course of rituximab the they do not meet the renewal criteria for rheumatoid arthritical course of rituximab the they do not meet the renewal criteria for rheumatoid arthritical course of rituximab the they do not meet the renewal criteria for rheumatoid arthritical course of rituximab the they do not meet the renewal criteria for rheumatoid arthritical course of rituximab the they do not meet the renewal criteria for rheumatoid arthritical course of rituximab the they do not meet the renewal criteria for rheumatoid arthritical course of rituximab the they do not meet the renewal criteria for rheumatoid arthritical course of rituximab the they do not meet the renewal criteria for rheumatoid arthritical course of rituximab the they do not meet the renewal criteria for rheumatoid arthritical course of rituximab the they do not meet the renewal criteria for rheumatoid arthritical course of rituximab the they do not meet the renewal criteria for rheumatoid arthritical course of rituximab the they do not meet the renewal criteria for rheumatoid arthritical course of rituximab the renewal criteria for rheumatoid arthritical course of rituximab the renewal criteria for rheumatoid arthritical course of rituximab the renewal criteria for rheumatoid arthritical course of rituximab the renewal criteria for rheumatoid arthritical course of rituximab the renewal criteria for rheumatoid arthritical course of rituximab the renewal c	h rituximab individual has received insufficient benefit such that
or O	(tick boxes where appropriate) Following 6 months' initial treatment, the individual has experienced at least On subsequent reapplications, the individual has experienced at least a cont baseline	
Re-assessmen	- Atopic dermatitis ent required after 6 months es (tick boxes where appropriate) Individual is currently on treatment with upadacitinib for atopic dermatitis and	d met all remaining criteria prior to commencing treatment
an	Individual has moderate to severe atopic dermatitis, severity as defined greater than or equal to 16 or a Dermatology Life Quality Index (DLQI) Individual has received insufficient benefit from topical therapy (includity for a 28-day trial within the last 6 months, unless contraindicated to all Individual has trialled and received insufficient benefit from at least one ciclosporin, azathioprine, methotrexate or mycophenolate mofetil), unleaded.	ng topical corticosteroids or topical calcineurin inhibitors) e systemic therapy for a minimum of three months (eg

ESCRIBER PATIENT:		
Name:	Name:	
ard:NHI:		
Upadacitinib - continued		
CONTINUATION – Atopic dermatitis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)		
O Individual has received a 75% or greater reduction in EASI sco upadacitinib or O Individual has received a DLQI improvement of 4 or more as co	ore (EASI 75) as compared to baseline EASI prior to commencing ompared to baseline DLQI prior to commencing upadacitinib	
INITIATION – Crohn's disease – adult Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)		
Individual is currently on treatment with upadacitinib for Crohn's disease and met all remaining criteria prior to commencing treatment Individual has active Crohn's disease Individual has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria Individual meets the initiation criteria for prior biologic therapies for Crohn's disease Other biologic therapies for Crohn's disease are contraindicated		
CONTINUATION – Crohn's disease – adult Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)		
CDAI score has reduced by 100 points from the CDAI score whor HBI score has reduced by 3 points from when individual was in CDAI score is 150 or less Or HBI score is 4 or less Or The individual has experienced an adequate response to treatr	nitiated on biologic therapy	

I confirm that the above details are correct:	
Signed:	Date:

May 2025

I confirm that the above details are correct:

Signed: Date:

PRESCRIBE	R PATIENT:
Name:	Name:
Ward:	NHI:
Upadacitir	nib - continued
INITIATION Re-assessm	- Crohn's disease - children ent required after 6 months es (tick boxes where appropriate)
or	Individual is currently on treatment with upadacitinib for Crohn's disease and met all remaining criteria prior to commencing treatment
	Child has active Crohn's disease
	Child has had an initial approval for prior biologic therapy for Crohn's disease and has experienced intolerable side effects or insufficient benefit to meet renewal criteria
	Child meets the initiation criteria for prior biologic therapies for Crohn's disease
	O Other biologic therapies for Crohn's disease are contraindicated
Re-assessm	CION – Crohn's disease – children ent required after 2 years es (tick boxes where appropriate)
or	PCDAI score has reduced by 10 points from when the child was initiated on treatment
	PCDAI score is 15 or less
or	The child has experienced an adequate response to treatment, but PCDAI score cannot be assessed
Note: Indica	tions marked with * are unapproved indications.
Re-assessm	- Ulcerative colitis ent required after 6 months es (tick boxes where appropriate)
or	Individual is currently on treatment with upadacitinib for ulcerative colitis and met all remaining criteria prior to commencing treatment
	O Individual has active ulcerative colitis
	Individual has had an initial approval for prior biologic therapy for ulcerative colitis and has experienced intolerable side effects or insufficient benefit to meet renewal criteria
	Individual meets the initiation criteria for prior biologic therapies for ulcerative colitis
	Other biologic therapies for ulcerative colitis are contraindicated
Re-assessm	CION – Ulcerative colitis ent required after 2 years es (tick boxes where appropriate)
or	The SCCAI score has reduced by 2 points or more from the SCCAI score when the individual was initiated on treatment
	PUCAI score has reduced by 10 points or more from the PUCAI score when the individual was initiated on treatment

Respiratory System and Allergies



PRES	CRIBER	PATIENT:
Name	:	Name:
Ward:		NHI:
lcatil	pant	
Re-a	endorsed by the Health NZ Hospital.	
Re-a	TINUATION ssessment required after 12 months equisites (tick box where appropriate) The treatment remains appropriate and the patient is benefiting from	treatment

PRES	SCR	IBER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Adre	na	line		
			anaphylaxis (tick boxes where appropriate)	
		0	Patient has experienced a previous anaphylactic reaction which	ch has resulted in presentation to a hospital or emergency department
	or	0	Patient has been assessed to be at significant risk of anaphyla	axis by a relevant practitioner

PRES	SCRIBER		PATIENT:
Name	e:		Name:
Ward	:		NHI:
Bee	venom		
	IATION equisites	(tick boxes where appropriate)	
	O	RAST or skin test positive	
	and	Patient has had severe generalised reaction to the sensitising	agent

I confirm that the above details are correct:

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Signed.	Date:	
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PRES	CRIBER		PATIENT:
Name	e:		Name:
Ward	:		NHI:
Pape	er wasp	venom	
	IATION equisites	(tick boxes where appropriate)	
	O	RAST or skin test positive	
	and	Patient has had severe generalised reaction to the sensitising	agent

C:	D-1	
Signed.	Date:	
Oigilica.	 Daic.	

PRES	CRIBER		PATIENT:
Name	e:		Name:
Ward	:		NHI:
Yello	w jack	et wasp venom	
	ATION equisites	(tick boxes where appropriate)	
	O	RAST or skin test positive	
	and	Patient has had severe generalised reaction to the sensitising	agent

May 2025

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Long-acting muscarinic antagonists with long-acting beta-	adrenoceptor agonists
INITIATION Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)	
Patient has been stabilised on a long acting muscarinic antage and The prescriber considers that the patient would receive addition	
CONTINUATION Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)	
Patient is compliant with the medication and Patient has experienced improved COPD symptom control (pro	escriber determined)

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Signed.	Date:	
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PRESCRIBER		PATIENT:
Name:		
Ward:		NHI:
Fluticasone	furoa	te with umeclidinium and vilanterol
INITIATION	/:: I I	
Prerequisites	(tick bo	xes where appropriate)
and	Patient possib	has a diagnosis of COPD confirmed by spirometry or spirometry has been attempted and technically acceptable results are not te
	and	Patient is currently receiving an inhaled corticosteroid with long acting beta-2 agonist (ICS/LABA) or a long acting muscarinic antagonist with long acting beta-2 agonist (LAMA/LABA)
or		Clinical criteria: O Patient has a COPD Assessment Test (CAT) score greater than 10 Or O Patient has had 2 or more exacerbations in the previous 12 months Or O Patient has had one exacerbation requiring hospitalisation in the previous 12 months Or O Patient has had an eosinophil count greater than or equal to 0.3 × 10°9 cells/L in the previous 12 months
	Į.	Patient is currently receiving multiple inhaler triple therapy (inhaled corticosteroid with long acting muscarinic antagonist and ong acting beta-2 agonist – ICS/LAMA/LABA) and met at least one of the clinical criteria above prior to commencing multiple inhaler triple therapy

I confirm that the above details are	correct:
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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	. NHI:
Budesonide with glycopyrronium and eformoterol	
INITIATION Prerequisites (tick boxes where appropriate) Patient has a diagnosis of COPD confirmed by spirometry of possible and Patient is currently receiving an inhaled corticos muscarinic antagonist with long acting beta-2 at and Clinical criteria: Patient has a COPD Assessment Test (Corticol Patient has had 2 or more exacerbations or Patient has had one exacerbation requiring or Patient has had an eosinophil count great or Patient is currently receiving multiple inhaler triple the	AT) score greater than 10 in the previous 12 months ag hospitalisation in the previous 12 months er than or equal to 0.3×10^9 cells/L in the previous 12 months
inhaler therapy	et at least one of the clinical criteria above prior to commencing multiple

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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	CRIE	BER		PATIENT:	
Name	:			Name:	
Ward:				NHI:	
Pirfe	nido	one			
Re-a	ssess siups	smer sites Prese	nt rec (tick cribe	opathic pulmonary fibrosis equired after 12 months ek boxes where appropriate) ed by, or recommended by a respiratory specialist, or in accordance with a bital.	
	and and and	\bigcirc	For Pirf	atient has been diagnosed with idiopathic pulmonary fibrosis by a multidisconced vital capacity is between 50% and 90% predicted rfenidone is to be discontinued at disease progression (See Notes) rfenidone is not to be used in combination with subsidised nintedanib	iplinary team including a radiologist
		or or	C	The patient has not previously received treatment with nintedanib Patient has previously received nintedanib, but discontinued nintedani Patient has previously received nintedanib, but the patient's disease hor more decline in predicted FVC within any 12 month period since sta	as not progressed (disease progression defined as 10%
CONTINUATION – idiopathic pulmonary fibrosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment and Pirfenidone is not to be used in combination with subsidised nintedanib and Pirfenidone is to be discontinued at disease progression (See Note)					
Note peri		ease	e pro	rogression is defined as a decline in percent predicted FVC of 10% or more	e within any 12 month

I confirm that the above details are correct:

. .		
Signed:	 Date:	

PRESCRIBER	PATIENT:				
Name:	Name:				
Ward: NHI:					
Nintedanib					
INITIATION – idiopathic pulmonary fibrosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a respiratory specialist, or in ac NZ Hospital. Patient has been diagnosed with idiopathic pulmonary fibrosi and Forced vital capacity is between 50% and 90% predicted and Nintedanib is to be discontinued at disease progression (See and Nintedanib is not to be used in combination with subsidised pand The patient has not previously received treatment with or Patient has previously received pirfenidone, but disconding	P Note) pirfenidone pirfenidone tinued pirfenidone within 12 weeks due to intolerance				
or more decline in predicted FVC within any 12 month	tient's disease has not progressed (disease progression defined as 10% period since starting treatment with pirfenidone)				
CONTINUATION – idiopathic pulmonary fibrosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a respiratory specialist, or in ac NZ Hospital. and	ccordance with a protocol or guideline that has been endorsed by the Health				
Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment Nintedanib is not to be used in combination with subsidised pirfenidone and Nintedanib is to be discontinued at disease progression (See Note)					
Note: disease progression is defined as a decline in percent predicted FVC period.	of 10% or more within any 12 month				

I confirm that the above details are correct:	
Signed:	Date:

PRES	CRIB	ER		P	ATIENT:
Name	e:			N	lame:
Ward	:			N	IHI:
Ivac	aftor				
	Э	ites Presc	ribed	boxes where appropriate) I by, or recommended by a respiratory specialist or paediatric by the Health NZ Hospital.	cian, or in accordance with a protocol or guideline that has been
O Patient has been diagnosed with cystic fibrosis					
	Patient must have G551D mutation in the cystic fibrosis 1 allele			unsmembrane conductance regulator (CFTR) gene on at least	
		0,	0	Patient must have other gating (class III) mutation (G1244I in the CFTR gene on at least 1 allele	E, G1349D, G178R, G551S, S1251N, S1255P, S549N and S549R)
	and (C		ents must have a sweat chloride value of at least 60 mmol/L	by quantitative pilocarpine iontophoresis or by Macroduct sweat
Treatment with ivacaftor must be given concomitantly with standard therapy for this condition and			ard therapy for this condition		
	and	C		ent must not have an acute upper or lower respiratory infection intension of pulmonary disease in the last 4 weeks prior to coro	on, pulmonary exacerbation, or changes in therapy (including mmencing treatment with ivacaftor
	and (C	The	dose of ivacaftor will not exceed one tablet or one sachet tw	ice daily
	and (C	Appli	icant has experience and expertise in the management of cy	ystic fibrosis

PRES	CRIB	ER	PATIENT:	
Name:			Name:	
Ward:			NHI:	
Elexa	caft	or	with tezacaftor, ivacaftor and ivacaftor	
INITI/ Prere		-	(tick boxes where appropriate)	
	(С	Patient has been diagnosed with cystic fibrosis	
	and (and	С	Patient is 6 years of age or older	
			O Patient has two cystic fibrosis-causing mutations in the cystic fibrosis transmembrane regulator (CFTR) gene (one from each parental allele)	
		or	O Patient has a sweat chloride value of at least 60 mmol/L by quantitative pilocarpine iontophoresis or by Macroduct sweat collection system	
	and		O Patient has a heterozygous or homozygous F508del mutation	
		or	O Patient has a G551D mutation or other mutation responsive in vitro to elexacaftor/tezacaftor/ivacaftor (see note a)	
	The treatment must be the sole funded CFTR modulator therapy for this condition			
	Treatment with elexacaftor/tezacaftor/ivacaftor must be given concomitantly with standard therapy for this condition			
Note:				
			tations are listed in the Food and Drug Administration (FDA) Trikafta prescribing information crs.fda.gov/fdalabel/services/spl/set-ids/f354423a-85c2-41c3-a9db-0f3aee135d8d/spl-doc	

I confirm that the above details are correct:

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Signed.	Date:	
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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: Name:						
Ward: NHI:						
Dornase alfa						
INITIATION – cystic fibrosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a respiratory physician or pae endorsed by the Health NZ Hospital. and O Patient has a confirmed diagnosis of cystic fibrosis and O Patient has previously undergone a trial with, or is currently and O Patient has required one or more hospital inpatient recor O Patient has had 3 exacerbations due to CF, requiring or O Patient has had 1 exacerbation due to CF, requiring of	spiratory admissions in the previous 12 month period oral or intravenous (IV) antibiotics in in the previous 12 month period oral or IV antibiotics in the previous 12 month period and a Brasfield score					
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 pae endorsed by the Health NZ Hospital. The treatment remains appropriate and the patient continues to be	diatrician, or in accordance with a protocol or guideline that has been enefit from treatment					
INITIATION – significant mucus production Re-assessment required after 4 weeks Prerequisites (tick boxes where appropriate) O 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:

Sensory Organs



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:	Name:			
Ward:	NHI:			
Dexamethasone				
INITIATION – Diabetic macular oedema Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by an ophthalmologist, or in according Hospital. and Patients have diabetic macular oedema with pseudophakic least and Patient has reduced visual acuity of between 6/9 – 6/48 with and O Patient's disease has progressed despite 3 injections with pseudophakic least and Patient is unsuitable or contraindicated to treatment with and O Patient is unsuitable or contraindicated to treatment with and Patient is unsuitable or contraindicated t	functional awareness of reduction in vision with bevacizumab th anti-VEGF agents			
O Dexamethasone implants are to be administered not more free of 3 implants per eye per year	equently than once every 4 months into each eye, and up to a maximum			
Hospital. O Patient's vision is stable or has improved (prescriber determinant)	dance with a protocol or guideline that has been endorsed by the Health NZ ned) equently than once every 4 months into each eye, and up to a maximum			
INITIATION – Women of child bearing age with diabetic macular oedema Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
Patients have diabetic macular oedema and Patient has reduced visual acuity of between 6/9 – 6/48 with and Patient is of child bearing potential and has not yet completed and Dexamethasone implants are to be administered not more free of 3 implants per eye per year				

I confirm that the above details are correct:

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Siurieu.	 Date.	

PRES	CRIE	BER		PATIENT:		
Name	e:			Name:		
Ward:	·			NHI:		
Dexamethasone - continued						
CONTINUATION – Women of child bearing age with diabetic macular oedema Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health Hospital. and						
	and		Patient's vision is stable or has improved (prescriber determine Patient is of child bearing potential and has not yet completed			
	uilu	0	Dexamethasone implants are to be administered not more freq of 3 implants per eye per year	quently than once every 4 months into each eye, and up to a maximum		

Various



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.

PATIENT:
Name:
NHI:
ue to congenital inherited anaemia ng/kg/day e monotherapy or deferiprone and desferrioxamine combination therapy levels, liver or cardiac MRI T2* istent vomiting or diarrhoea history of agranulocytosis (defined as an absolute neutrophil count
ater than 2 episodes) of moderate neutropenia (ANC 0.5 - 1.0 cells per
nce with a protocol or guideline that has been endorsed by the Health NZ
nt has been tolerated and has resulted in clinical improvement in all three MRI T2* levels and has resulted in clinical stability or continued improvement in all three

Signed: Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Deferiprone	
INITIATION	
Prerequisites (tick box where appropriate)	
O Patient has been diagnosed with chronic iron overload due to conge	nital inherited anaemia or acquired red cell aplasia

Page 472

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Povidone-iodine - Vaginal tab 200 mg	
INITIATION Prerequisites (tick box where appropriate)	
O Rectal administration pre-prostate biopsy	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Chlorhexidine with cetrimide	
INITIATION Re-assessment required after 3 months Prerequisites (tick boxes where appropriate) Patient has burns that are greater than 30% of total body surface and For use in the perioperative preparation and cleansing of large and The use of 30 ml ampoules is impractical due to the size of the	e burn areas requiring debridement/skin grafting
CONTINUATION Re-assessment required after 3 months Prerequisites (tick box where appropriate)	
The treatment remains appropriate for the patient and the patient is	benefiting from the treatment

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Signed.	Date:	
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Special Foods



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

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Carbohydrate	
INITIATION – Use as an additive Prerequisites (tick boxes where appropriate)	
O Cystic fibrosis	
Or Chronic kidney disease	
Cancer in children	
	malabsorption problems in patients over the age of 20 years
O Faltering growth in an infant/child or	
O Bronchopulmonary dysplasia	
O Premature and post premature infant or	
O Inborn errors of metabolism	
INITIATION – Use as a module	
Prerequisites (tick box where appropriate)	
For use as a component in a modular formula made from the Pharmaceutical Schedule or breast milk Note: Patients are required to meet any Special Authority criteria a	n at least one nutrient module and at least one further product listed in Section D of associated with all of the products used in the modular formula.

I confirm that the above details are correct:

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Signed.	Date:	
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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.	e. For community funding, see the Special Authority Criteria.	
PRESCR	RIBER	PATIENT:
Name:		Name:
Ward:		NHI:
Fat		
	TION – Use as an additive uisites (tick boxes where appropriate)	
or	O Patient has inborn errors of metabolism	
or	O Faltering growth in an infant/child	
or	O Bronchopulmonary dysplasia	
or	O Fat malabsorption	
or	O Lymphangiectasia	
or	O Short bowel syndrome	
or	O Infants with necrotising enterocolitis	
or	O Biliary atresia	
or	O For use in a ketogenic diet	
or	O Chyle leak	
or	Ascites	
	O Patient has increased energy requirements, and for whom di	etary measures have not been successful
INITIATI	TION – Use as a module	
	uisites (tick box where appropriate)	
Note: Pa	For use as a component in a modular formula made from at least of the Pharmaceutical Schedule or breast milk. Patients are required to meet any Special Authority criteria associated	one nutrient module and at least one further product listed in Section D of with all of the products used in the modular formula.

I confirm that the above details are correct: Signed: Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Protein	
INITIATION – Use as an additive Prerequisites (tick boxes where appropriate)	
O Protein losing enteropathy or	
O High protein needs	
INITIATION – Use as a module Prerequisites (tick box where appropriate)	
O For use as a component in a modular formula made from at least on the Pharmaceutical Schedule or breast milk. Note: Patients are required to meet any Special Authority criteria associated v	ne nutrient module and at least one further product listed in Section D of with all of the products used in the modular formula.

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Zigneg.	i jate:	
Oigilica.	 Duic.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Carbohydrate and fat supplement	
INITIATION Prerequisites (tick boxes where appropriate)	
Infant or child aged four years or under	
Cystic fibrosis Or Cancer in children Or Faltering growth Or Bronchopulmonary dysplasia Or Premature and post premature infants	

I confirm that the above details are correct:

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Signed.	Date:	
Oigilica.	 Daic.	

PRES	SCR	IBER	PATIENT:
Name	e:		Name:
Ward	l:		NHI:
Metabolic Products			
INITIATION Prerequisites (tick boxes where appropriate)			
		O For the dietary management of inherited metabolic disease	
	or	O Patient has adrenoleukodystrophy	

PRESCRIBER				PATIENT:
Name	:			Name:
Ward:				NHI:
Diab	etic	Pro	ducts	
INITI. Prere			(tick boxes where appropriate)	
	O For patients with type I or type II diabetes suffering weight loss and malnutrition that requires nutritional support			and malnutrition that requires nutritional support
	or	0	For patients with pancreatic insufficiency	
	or	0	For patients who have, or are expected to, eat little or nothing to	or 5 days
	or	0	For patients who have a poor absorptive capacity and/or high r catabolism	nutrient losses and/or increased nutritional needs from causes such as
	or	0	For use pre- and post-surgery	
	or	0	For patients being tube-fed	
	or	\circ	For tube-feeding as a transition from intravenous nutrition	

I confirm that the above details are correct:		
Signed:	Date:	

PRESC	RII	BER		PATIENT:
Name:				Name:
Ward:				NHI:
Eleme	ent	al a	nd Semi-Elemental Products	
INITIA Prerec			(tick boxes where appropriate)	
	O Malabsorption or		Malabsorption	
	or	0	Short bowel syndrome	
	or	\bigcirc	Enterocutaneous fistulas	
	or		Eosinophilic enteritis (including oesophagitis)	
	or		Inflammatory bowel disease	
	or		Acute pancreatitis where standard feeds are not tolerated Patients with multiple food allergies requiring enteral feeding	
			rations with multiple tood allergies requiring enteral leeding	

I confirm that the above details are correct:	

Signed: Date:

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	CRII	BER		PATIENT:
Name:				Name:
Ward:				NHI:
Fat-n	nod	lified	l feed	
INITIATION Prerequisites (tick boxes where appropriate)		(tick boxes where appropriate)		
		O	Patient has metabolic disorders of fat metabolism	
	or	0	Patient has a chyle leak	
	or		Modified as a modular feed, made from at least one nutrient me Pharmaceutical Schedule, for adults	odule and at least one further product listed in Section D of the

Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Hepatic Products	
INITIATION Prerequisites (tick box where appropriate)	
O For children (up to 18 years) who require a liver transplant	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
High Calorie Products	
INITIATION Prerequisites (tick boxes where appropriate) O Patient is fluid volume or rate restricted or O Patient requires low electrolyte or O Cystic fibrosis or O Any condition causing malabsorption or O Faltering growth in an infant/child or O Increased nutritional requirements and O Patient has substantially increased metabolic requirements	ents

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Signed.	Date:	
Oigilica.	 Daic.	

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
High protein enteral feed		
INITIATION Prerequisites (tick boxes where appropriate) The patient has a high protein requirement and Patient has liver disease or Patient is obese (BMI > 30) and is undergoing surgery or Patient is fluid restricted or Patient's needs cannot be more appropriately met using	g high calorie product	

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Extensively hydrolysed formula			
INITIATION Prerequisites (tick boxes where appropriate)			
O Cows' milk formula is inappropriate due to severe intole	erance or allergy to its protein content		
O Soy milk formula has been reasonably trialled wi			
O Soy milk formula is considered clinically inapprop	riate or contraindicated		
or O Severe malabsorption			
O Short bowel syndrome			
Or Intractable diarrhoea			
O Biliary atresia			
O Cholestatic liver diseases causing malsorption			
Or Cystic fibrosis			
or Proven fat malabsorption			
or Severe intestinal motility disorders causing significant malabs	sorption		
or Intestinal failure			
or			
Note: A reasonable trial is defined as a 2-4 week trial, or signs of an immediate IgE mediated allergic reaction.			
CONTINUATION Prerequisites (tick boxes where appropriate)			
	o a cows' milk protein or soy infant formula has been undertaken		
The outcome of the assessment is that the infant continues to	o require an extensively hydrolysed infant formula		

I confirm that the above details are correct:	

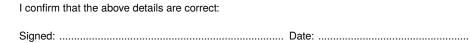
Signed: Date:

Form RS1224 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Preterm formula	
INITIATION Prerequisites (tick box where appropriate)	
O For infants born before 33 weeks' gestation or weighing less than 1.8	5 kg at birth



PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Paediatric oral/enteral feed 1 kcal/ml	
INITIATION – Fluid restricted or volume intolerance with faltering growth Prerequisites (tick boxes where appropriate)	
The patient is fluid restricted or volume intolerant or The patient has increased nutritional requirements due to	to faltering growth
and O Patient is under 18 months old and weighs less than 8kg	
Note: 'Volume intolerant' patients are those who are unable to tolerate an ade patients should have first trialled appropriate clinical alternative treatments, su	equate volume of infant formula to achieve expected growth rate. These uch as concentrating, fortifying and adjusting the frequency of feeding.

I confirm that the above details are correct:

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PRESCRIBE	PATIENT:
Name:	
Ward:	
Enteral liq	uid peptide formula
INITIATION Prerequisite	es (tick boxes where appropriate)
and	Patient has impaired gastrointestinal function and either cannot tolerate polymeric feeds, or polymeric feeds are unsuitable
	O Severe malabsorption
	O Short bowel syndrome
	O Intractable diarrhoea
	or O Biliary atresia
	or Cholestatic liver diseases causing malabsorption
	O Cystic fibrosis
	or
	O Proven fat malabsorption
	Severe intestinal motility disorders causing significant malabsorption
	O Intestinal failure
	The patient is currently receiving funded amino acid formula
	The patient is to be trialled on, or transitioned to, an enteral liquid peptide formula
and	
	O A semi-elemental or partially hydrolysed powdered feed has been reasonably trialled and considered unsuitable
	O For step down from intravenous nutrition
Note: A rea	sonable trial is defined as a 2-4 week trial.
CONTINUA	TION
Prerequisit	es (tick boxes where appropriate)
and	An assessment as to whether the patient can be transitioned to a cows milk protein or soy infant formula or extensively hydrolysed formula has been undertaken
	The outcome of the assessment is that the patient continues to require an enteral liquid peptide formula

I confirm that the above details are correct:

Signed: Date:

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:	Name:	
/ard:NHI:		
Amino acid formula		
INITIATION Prerequisites (tick boxes where appropriate)		
Extensively hydrolysed formula has been reasonably trialled for or allergy or malabsorption O History of anaphylaxis to cows' milk protein formula or dairy proor O Eosinophilic oesophagitis Or O Ultra-short gut O Severe Immune deficiency	or 2-4 weeks and is inappropriate due to documented severe intolerance oducts	
CONTINUATION Prerequisites (tick boxes where appropriate) An assessment as to whether the infant can be transitioned to been undertaken The outcome of the assessment is that the infant continues to and Amino acid formula is required for a nutritional deficit	a cows' milk protein, soy, or extensively hydrolysed infant formula has require an amino acid infant formula	
INITIATION – patients who are currently funded under RS1502 or SA1557 Re-assessment required after 3 months Prerequisites (tick boxes where appropriate) Patient has a valid initiation or renewal approval for extensively hydrolysed formula (RS1502) Patient is unable to source funded Aptamil powder at this time and The approval only applies to funded dispensings of Neocate Gold and Neocate Syneo Note: This criteria is short term funding to cover an out-of-stock situation on some extensively hydrolysed formula powder funded under Hospital Restriction RS1502. There is no continuation criteria under this criterion.		
I confirm that the above details are correct:		

Signed: Date:

	PRESCR	IBER	PATIENT:
	Name:		Name:
	Ward:		NHI:
ı	High fa	t formula	
	INITIATI Prerequ	ON isites (tick box where appropriate)	
	0	For patients with intractable epilepsy, pyruvate dehydrogenase defice requiring a ketogenic diet	ciency or glucose transported type-1 deficiency and other conditions

PRESCF	RIBEF	?		PATIENT:
Name: .				Name:
Ward:				NHI:
Paedia	tric	Produ	ıcts	
INITIAT Prerequ		s (tick t	poxes where appropriate)	
ar		Child	I is aged one to ten years	
	C	, O	The child is being fed via a tube or a tube is to be inserted	ed for the purposes of feeding
		$_{r}$ O	Any condition causing malabsorption	
		\circ	Faltering growth in an infant/child	
		\circ	Increased nutritional requirements	
		\circ	The child is being transitioned from TPN or tube feeding	to oral feeding
	0	O	The child has eaten, or is expected to eat, little or nothin	g for 3 days
		r ()	Any condition causing malabsorption Faltering growth in an infant/child Increased nutritional requirements The child is being transitioned from TPN or tube feeding	to oral feeding

I confirm that the above details are correct:	
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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Low electrolyte oral feed	
INITIATION Prerequisites (tick box where appropriate)	
O For children (up to 18 years) with acute or chronic kidney disease	

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Signed.	Date:	
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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Low electrolyte oral feed	
INITIATION	
Prerequisites (tick box where appropriate)	
O For patients with acute or chronic kidney disease	

PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Preoperative carbohydrate feed 0.5 kcal/ml				
INITIATION				
Prerequisites (tick box where appropriate)				
O Maximum of 400 ml as part of an Enhanced Recovery After Surgery (ERAS) protocol 2 to 3 hours before major abdominal surgery				

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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:	Name:
Ward:	NHI:
High arginine oral feed 1.4 kcal/ml	
INITIATION Prerequisites (tick box where appropriate)	
O Three packs per day for 5 to 7 days prior to major gastrointestinal, h	ead or neck surgery

I confirm that the above details are correct:

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PRESC	CRIE	BER	PATIENT:
Name:			
Ward:			NHI:
Stand	larc	d Fe	eds
INITIA	TIO	N	
Prere	quis	ites	(tick boxes where appropriate)
		For p	patients with malnutrition, defined as any of the following:
			O BMI < 18.5
		or	O Greater than 10% weight loss in the last 3-6 months
		or	O BMI < 20 with greater than 5% weight loss in the last 3-6 months
	or	\bigcirc	For patients who have, or are expected to, eat little or nothing for 5 days
	or	\sim	To patients who have, or are expected to, car little of horizing for 5 days
	or	\bigcirc	For patients who have a poor absorptive capacity and/or high nutrient losses and/or increased nutritional needs from causes such as catabolism
		\circ	For use pre- and post-surgery
O For patients being tube-fed		For patients being tube-fed	
	or	0	For tube-feeding as a transition from intravenous nutrition
	or	0	For any other condition that meets the community Special Authority criteria

I confirm that the above details are correct:

Signed: Date:

Vaccines



PRES	CRII	BER		PATIENT:
Name	:			Name:
Ward:				NHI:
Diph	the	ria, t	tetanus, pertussis and polio vaccine	
INITI Prere			(tick boxes where appropriate)	
		0	A single dose for children up to the age of 7 who have comple	ted primary immunisation
A course of up to four vaccines is funded for catch up programmes for children (to the age of 10 years) to immunisation		nmes for children (to the age of 10 years) to complete full primary		
	An additional four doses (as appropriate) are funded for (re-)immunisation for patients post HSCT, or chemotherapy; pre- or post splenectomy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens			
	or	0	Five doses will be funded for children requiring solid organ tra	nsplantation
Note	e: Ple	ease	refer to the Immunisation Handbook for appropriate schedule fo	or catch up programmes

I confirm that the above details are correct:	
Signed:	Date:

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	CRI	BER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Diph	the	ria, t	tetanus, pertussis, polio, hepatitis B and haemo	ophilus influenzae type B vaccine
Pren			transplantation	of children under the age of 18 years post haematopoietic stem cell of children under the age of 10 years who are post chemotherapy; pre rely immunosuppressive regimens

Note: A course of up-to four vaccines is funded for catch up programmes for children (up to and under the age of 10 years) to complete full primary immunisation. Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes.

I confirm that the above details are correct:		
Signed:	Date:	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Bacillus calmette-guerin vaccine	
INITIATION Prerequisites (tick boxes where appropriate)	
For infants at increased risk of tuberculosis defined as:	
O Living in a house or family with a person with current or past h	nistory of TB
Having one or more household members or carers who within 100,000 for 6 months or longer	the last 5 years lived in a country with a rate of TB > or equal to 40 per
During their first 5 years will be living 3 months or longer in a d	country with a rate of TB > or equal to 40 per 100,000

Note: A list of countries with high rates of TB are available at http://www.health.govt.nz/tuberculosis (Search for Downloads) or www.bcgatlas.org/index.php

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.

RESCR	BER	R PATIEN	п:	
lame:				
Vard:		NHI:		
iphthe	ria, i	, tetanus and pertussis vaccine		
INITIATIO Prerequi		es (tick boxes where appropriate)		
or	0	A single dose for pregnant women in the second or third trimester of ea	ach pregnancy; or	
	0	A single dose for parents or primary caregivers of infants admitted to a more than 3 days, who had not been exposed to maternal vaccination a		
or	0	A course of up to four doses is funded for children from age 7 up the age of 18 years inclusive to complete full primary immunisation		
	O An additional four doses (as appropriate) are funded for (re-)immunisation for patients post haematopoietic stem cell transplantation or chemotherapy; pre or post splenectomy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens			
or	0	A single dose for vaccination of patients aged from 65 years old		
or	0	A single dose for vaccination of patients aged from 45 years old who ha	ave not had 4 previous tetanus doses	
or	0	O For vaccination of previously unimmunised or partially immunised patients		
or	O For revaccination following immunosuppression			
	0	For boosting of patients with tetanus-prone wounds		

Note: Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes.

I confirm that the above details are correct:	
Signed:	Date:

PRES	CRI	BER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Haer	nop	hilu	s influenzae type B vaccine	
	sses	smen	t required after 1 dose (tick boxes where appropriate)	
		0	For primary vaccination in children	
	An additional dose (as appropriate) is funded for (re-)immunisation for patients post haematopoietic stem cell transplantation, or chemotherapy; functional asplenic; pre or post splenectomy; pre- or post solid organ transplant, pre- or post cochlear implants, rendialysis and other severely immunosuppressive regimens			
O For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or pa				he recommendation of an internal medicine physician or paediatrician

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:
Mening	jocod	cal	(A, C, Y and W-135) conjugate vaccine
INITIATI	ION		
Prerequ	uisites	(tick b	poxes where appropriate)
		0	Up to three doses and a booster every five years for patients pre- and post splenectomy and for patients with HIV, complement deficiency (acquired or inherited), functional or anatomic asplenia or pre or post solid organ transplant
	or	0	One dose for close contacts of meningococcal cases of any group
	or	0	One dose for person who has previously had meningococcal disease of any group
	or	0	A maximum of two doses for bone marrow transplant patients
		0	A maximum of two doses for person pre and post-immunosuppression*
or	·		
	an		Person is aged between 13 and 25 years, inclusive
		or	One dose for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, or prisons
		U.	One dose for individuals who turn 13 years of age while living in boarding school hostels

Note: children under seven years of age require two doses 8 weeks apart, a booster dose three years after the primary series and then five yearly.

*Immunosuppression due to steroid or other immunosuppressive therapy must be for a period of greater than

*Immunosuppression due to steroid or other immunosuppressive therapy must be for a period of greater than 28 days.

I confirm that the above details are correct:	
Signed:	Date:

PRESCR	IBER		PATIENT:
Name:			Name:
Ward:			NHI:
Mening	осо	ccal (A, C, Y and W-135) conjugate vaccine	
		Children under 12 months of age (tick boxes where appropriate)	
or or or	0 0 0	anatomic asplenia, HIV, complement deficiency (acquired or in A maximum of three doses (dependant on age at first dose) for	or close contacts of meningococcal cases of any group or child who has previously had meningococcal disease of any group or bone marrow transplant patients
		from 6 weeks to less than 6 months of age require a 2+1 scheths of age require a 1+1 schedule. Refer to the Immunisation H	

*Immunosuppression due to steroid or other immunosuppressive therapy must be for a period of greater than 28 days.

I confirm that the above details are correct:

schedules with meningococcal ACWY vaccine.

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PRESCRIBER	PATIENT:
Name:	
Ward:	NHI:
Pneumococcal	(PCV13) conjugate vaccine
Re-assessment req	ary course for previously unvaccinated children aged under 5 years quired after 3 doses box where appropriate)
O A primary	course of three doses for previously unvaccinated children up to the age of 59 months inclusive
Re-assessment req Prerequisites (tick Two doses	risk individuals who have received PCV10 quired after 2 doses box where appropriate) s are funded for high risk individuals (over the age of 12 months and under 18 years) who have previously received two doses of the ourse of PCV10
Re-assessment req Prerequisites (tick	risk children aged under 5 years quired after 4 doses boxes where appropriate) to an additional four doses (as appropriate) are funded for the (re)immunisation of high-risk children aged under 5 years
and or or or or or or or or or o	On immunosuppressive therapy or radiation therapy, vaccinate when there is expected to be a sufficient immune response Primary immune deficiencies HIV infection Renal failure, or nephrotic syndrome Are immune-suppressed following organ transplantation (including haematopoietic stem cell transplant) Cochlear implants or intracranial shunts Cerebrospinal fluid leaks Receiving corticosteroid therapy for more than two weeks, and who are on an equivalent daily dosage of prednisone of 2 mg/kg per day or greater, or children who weigh more than 10 kg on a total daily dosage of 20 mg or greater Chronic pulmonary disease (including asthma treated with high-dose corticosteroid therapy) Pre term infants, born before 28 weeks gestation Cardiac disease, with cyanosis or failure Diabetes Down syndrome

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Pneumococcal (PCV13) conjugate vaccine - continued				
INITIATION – High risk individuals 5 years and over Re-assessment required after 4 doses				
Prerequisites (tick box where appropriate)				
O Up to an additional four doses (as appropriate) are funded for the (re-)immunisation of individuals 5 years and over with HIV, pre or post haematopoietic stem cell transplantation, or chemotherapy; pre- or post splenectomy; functional asplenia, pre- or post- solid organ transplant, renal dialysis, complement deficiency (acquired or inherited), cochlear implants, intracranial shunts, cerebrospinal fluid leaks or primary immunodeficiency				
INITIATION – Testing for primary immunodeficiency diseases				
Prerequisites (tick box where appropriate)				
O For use in testing for primary immunodeficiency diseases, on the rec	commendation of an internal medicine physician or paediatrician			
Note: Please refer to the Immunisation Handbook for the appropriate schedu	ule for catch up programmes			

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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.

e:	Name:
:	
	NHI:
umococcal (PPV23) polysaccharide vaccine	
IATION – High risk patients assessment required after 3 doses equisites (tick box where appropriate)	
	ell transplant, or chemotherapy; pre- or post-splenectomy; or with functional mplement deficiency (acquired or inherited), cochlear implants, or primary
IATION – High risk children assessment required after 2 doses	
requisites (tick boxes where appropriate)	
Patient is a child under 18 years for (re-)immunisation	
or	py, vaccinate when there is expected to be a sufficient immune response
or With primary immune deficiencies With HIV infection	
Or With renal failure, or nephrotic syndrome or	
	splantation (including haematopoietic stem cell transplant)
O With cochlear implants or intracranial shunts	
or Receiving corticosteroid therapy for more than two	o weeks, and who are on an equivalent daily dosage of prednisone of 2 mg/kg
	an 10 kg on a total daily dosage of 20 mg or greater
or O Pre term infants, born before 28 weeks gestation	The date with high door controlled the rapy)
O With cardiac disease, with cyanosis or failure or	
O With diabetes	
or With Down syndrome O Who are pre-or post-splenectomy, or with functional	al acalonia
with are pre-of post-spierrectority, of with functional	ai aspietiia
IATION – Testing for primary immunodeficiency diseases equisites (tick box where appropriate)	
	the recommendation of an internal medicine physician or paediatrician

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Signeg	 Date	

Form RS1243 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:	Name:
Ward:	NHI:
Salmonella typhi vaccine	
INITIATION	
Prerequisites (tick box where appropriate)	
O For use during typhoid fever outbreaks	

I confirm that the above details are correct:

Signed: Date:

RESCRI	IBER	PATIENT:
ame:		Name:
ard:		NHI:
eninge	ococcal B multicomponent vaccine	
e-asses	ON – Primary immunisation for children up to 12 months of age ssment required after 3 doses isites (tick boxes where appropriate)	
or	O Three doses for children up to 12 months of age (inclusive) for O Up to three doses (dependent on age at first dose) for a cato (inclusive) for primary immunisation, from 1 March 2023 to 3	h-up programme for children from 13 months to 59 months of age
	ON – Person is one year of age or over isites (tick boxes where appropriate)	
or or or	Up to two doses and a booster every five years for patients pasplenia, HIV, complement deficiency (acquired or inherited) Up to two doses for close contacts of meningococcal cases of the complement deficiency (acquired or inherited) Up to two doses for person who has previously had meningood the complement doses for bone marrow transplant patients Up to two doses for person pre- and post-immunosuppression	of any group secoccal disease of any group
-asses	ON – Person is aged between 13 and 25 years (inclusive) assment required after 2 doses isites (tick boxes where appropriate)	
and		·
	Immunosuppression due to corticosteroid or other immunosuppresthan 28 days.	ssive therapy must be for a period of

I confirm that the above details are correct:

Signed: Date:

PRES	SCR	IBER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Нера	atiti	s A v	vaccine	
INITI Prer			(tick boxes where appropriate)	
		0	Two vaccinations for use in transplant patients	
	or	0	Two vaccinations for use in children with chronic liver disease	
	JI	\circ	One dose of vaccine for close contacts of known hepatitis A ca	ases

PRESCRI	BER	PATIENT:	
Name:		Name:	
Ward:		NHI:	
Hepatiti	s B	s recombinant vaccine	
INITIATIO Prerequi		s (tick boxes where appropriate)	
or	0	For household or sexual contacts of known acute hepatitis B patients or hepatitis B carriers	
or	0	For children born to mothers who are hepatitis B surface antigen (HBsAg) positive For children up to and under the age of 18 years inclusive who are considered not to have achieved a positive serology and require additional vaccination or require a primary course of vaccination	
or	O O	For HIV positive patients For hepatitis C positive patients	
or	O O	For patients following non-consensual sexual intercourse For patients prior to planned immunosuppression for greater than 28 days	
or or	0	For patients following immunosuppression	
or	0	For solid organ transplant patients For post-haematopoietic stem cell transplant (HSCT) patients	
or	O	Following needle stick injury For dialysis patients	
or	0	For liver or kidney transplant patients	

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Signed.	Date:	
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PRESCR	IBER	PATIENT:	
Name:	ne:Name:		
Ward:		NHI:	
Hepatiti	s B ı	recombinant vaccine	
INITIATION Prerequ		(tick boxes where appropriate)	
	0	For household or sexual contacts of known acute hepatitis B patients or hepatitis B carriers	
	0	For children born to mothers who are hepatitis B surface antigen (HBsAg) positive	
O For children up to and under the age of 18 years inclusive who are considered not to have achieved a positive se		For children up to and under the age of 18 years inclusive who are considered not to have achieved a positive serology and require additional vaccination or require a primary course of vaccination	
or			
	0	For hepatitis C positive patients	
	0	For patients following non-consensual sexual intercourse	
	0	For patients prior to planned immunosuppression for greater than 28 days	
or	0	For patients following immunosuppression	
or	0	For solid organ transplant patients	
or	\bigcirc	For post-haematopoietic stem cell transplant (HSCT) patients	
	0	Following needle stick injury	
or or or or	000000000	For children born to mothers who are hepatitis B surface antigen (HBsAg) positive For children up to and under the age of 18 years inclusive who are considered not to have achieved a positive serology and require additional vaccination or require a primary course of vaccination For HIV positive patients For hepatitis C positive patients For patients following non-consensual sexual intercourse For patients prior to planned immunosuppression for greater than 28 days For patients following immunosuppression For solid organ transplant patients For post-haematopoietic stem cell transplant (HSCT) patients	

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Influenza vaccine Inj 60 mcg in 0.5 ml syringe (quadrivalen	t vaccine)
INITIATION – People over 65 Prerequisites (tick box where appropriate) The patient is 65 years of age or over	
INITIATION – cardiovascular disease Prerequisites (tick boxes where appropriate)	
O Ischaemic heart disease or O Congestive heart failure or O Rheumatic heart disease or O Congenital heart disease or O Cerebro-vascular disease	
Note: hypertension and/or dyslipidaemia without evidence of end-organ disea	se is excluded from funding.
INITIATION – chronic respiratory disease Prerequisites (tick boxes where appropriate)	
O Asthma, if on a regular preventative therapy Or Other chronic respiratory disease with impaired lung function	
Note: asthma not requiring regular preventative therapy is excluded from fund	ing.

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I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:
Name:	
Ward:	NHI:
Influenza va	ccine Inj 60 mcg in 0.5 ml syringe (quadrivalent vaccine) - continued
	Other conditions (tick boxes where appropriate)
or or or	O Diabetes O Chronic renal disease O Any cancer, excluding basal and squamous skin cancers if not invasive O Autoimmune disease
or or or or or or or	Immune suppression or immune deficiency HIV Transplant recipient Neuromuscular and CNS diseases/ disorders Haemoglobinopathies Is a child on long term aspirin Has a cochlear implant Errors of metabolism at risk of major metabolic decompensation Pre and post splenectomy Down syndrome Is pregnant Is a child 4 years of age or under (inclusive) who has been hospitalised for respiratory illness or has a history of significant
or O	Patients in a long-stay inpatient mental health care unit or who are compulsorily detained long-term in a forensic unit within a Public Hospital
	Serious mental health conditions or addiction (tick boxes where appropriate)
or O or O or O	Schizophrenia Major depressive disorder Bipolar disorder Schizoaffective disorder Person is currently accessing secondary or tertiary mental health and addiction services

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Measles, mumps and rubella vaccine	
INITIATION – first dose prior to 12 months Re-assessment required after 3 doses Prerequisites (tick boxes where appropriate) Or Or Or For primary vaccination in children or Or For revaccination following immunosuppression or Or For any individual susceptible to measles, mumps or rubella	
INITIATION – first dose after 12 months Re-assessment required after 2 doses Prerequisites (tick boxes where appropriate)	
For primary vaccination in children or For revaccination following immunosuppression or For any individual susceptible to measles, mumps or rubella	
Note: Please refer to the Immunisation Handbook for appropriate schedule for	or catch up programmes.

I confirm that the above details are correct:	
Signed:	Date:

PRES	SCR	IBER	PATIENT:
Name	e:		Name:
Ward	:		NHI:
Polic	omy	yelitis vaccine	
	sse	ON ssment required after 3 doses isites (tick boxes where appropriate)	
		O For partially vaccinated or previously unvaccinated individuals	
	or	O For revaccination following immunosuppression	

Note: Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes.

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May 2025

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Varicella vaccin	cine [Chickenpox vaccine]	
Re-assessment req Prerequisites (tick	imary vaccinations required after 1 dose ick boxes where appropriate) Any infant born on or after 1 April 2016	
	for previously unvaccinated children turning 11 years old on or after 1 July 2017, who have chickenpox)	not previously had a varicella infection
	her conditions required after 2 doses ick boxes where appropriate)	
or O or O	For non-immune patients: With chronic liver disease who may in future be candidates for transplantation With deteriorating renal function before transplantation Prior to solid organ transplant Prior to any elective immunosuppression* For post exposure prophylaxis who are immune competent inpatients	
or O For Or Or Or Or Or Or OF Or OF	For patients at least 2 years after bone marrow transplantation, on advice of their specialist for patients at least 6 months after completion of chemotherapy, on advice of their specialist for HIV positive patients non immune to varicella with mild or moderate immunosuppression for patients with inborn errors of metabolism at risk of major metabolic decompensation, with for household contacts of paediatric patients who are immunocompromised, or undergoing where the household contact has no clinical history of varicella and who are indergoing a procedure leading to immune compromise where the household contact has no	n on advice of HIV specialist th no clinical history of varicella a procedure leading to immune compromise e severely immunocompromised or
Note: * immunosu greater than 28 da	suppression due to steroid or other immunosuppressive therapy must be for a treatment per days	riod of

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Human papillomavirus (6, 11, 16, 18, 31, 33, 45, 52 and 5	B) vaccine [HPV]
INITIATION – Children aged 14 years and under Re-assessment required after 2 doses Prerequisites (tick box where appropriate)	
O Children aged 14 years and under	
INITIATION – other conditions Prerequisites (tick boxes where appropriate)	
Up to 3 doses for people aged 15 to 26 years inclusive	
People aged 9 to 26 years inclusive	
O Up to 3 doses for confirmed HIV infection or	
O Up to 3 doses people with a transplant (includi	ng stem cell)
O Up to 4 doses for Post chemotherapy	
INITIATION – Recurrent Respiratory Papillomatosis Prerequisites (tick boxes where appropriate)	
O Maximum of two doses for children aged 14 years at	nd under
O Maximum of three doses for people aged 15 years a	nd over
The person has recurrent respiratory papillomatosis	
O The person has not previously had an HPV vaccine	

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PRESCRIBER		PATIENT:	
Name:		Name:	
Ward:		NHI:	
Rotavirus oral vaccine			
INITIATION Re-assessment required after 2 doses Prerequisites (tick boxes where appropria	te)		
	ed in infants aged under 14 weeks	of age	
O No vaccination being admi	nistered to children aged 24 weeks	or over	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Varicella zoster vaccine [shingles vaccine]	
INITIATION – people aged 18 years and over (Shingrix) Re-assessment required after 2 doses Prerequisites (tick boxes where appropriate)	
Pre- and post-haematopoietic stem cell transplant or cellular the pre- or post-solid organ transplant Pre- or post-solid organ transplant Haematological malignancies People living with poorly controlled HIV infection Planned or receiving disease modifying anti-rheumatic drugs (polymyalgia rheumatica, systemic lupus erythematosus or rhe polymyalgia rheumatica, systemic lupus erythematosus or rhe primary immunodeficiency	DMARDs – targeted synthetic, biologic, or conventional synthetic) for

Form RS2042 May 2025

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:	Name:
Ward:	NHI:
COVID-19 vaccine	
INITIATION – initial dose	
Prerequisites (tick box where appropriate)	
O Up to three doses for previously unvaccinated children aged 6 mon	ths – 4 years at high risk of severe illness

C:	D-1	
Signed.	Date:	
Oigilica.	 Daic.	

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	SCR	IBER	PATIENT:
Name	e:		Name:
Ward:	:		NHI:
COV	ID-	19 vaccine	
		ON – initial dose iisites (tick boxes where appropriate)	
		One dose for previously unvaccinated children aged 5-11 year	rs old
	or	O Up to three doses for immunocompromised children aged 5-11	1 years old

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
COVID-19 vaccine	
INITIATION – initial dose	
Prerequisites (tick boxes where appropriate)	
One dose for previously unvaccinated people aged 12-15 yea O Up to three doses for immunocompromised people aged 12-1	
or Up to two doses for previously unvaccinated people 16-29 year or	
O Up to four doses for people aged 16-29 at high risk of severe or	llness
One dose for previously unvaccinated people aged 30 and old	er
INITIATION – additional dose Prerequisites (tick box where appropriate)	
One additional dose every 6 months for people aged 30 years and c	ver, additional dose is given at least 6 months after last dose
CONTINUATION – additional dose Prerequisites (tick box where appropriate) One additional dose every 6 months for people aged 30 years and compared to the co	ver, additional dose is given at least 6 months after last dose
, , , , , , , , , , , , , , , , , , , ,	

C:	D-1	
Signed.	Date:	
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