# HOSPITAL MEDICINES LIST
# RESTRICTIONS CHECKLIST



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

**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

## Epoetin alfa

**INITIATION – chronic renal failure**

**Prerequisites** (tick boxes where appropriate)

- ○ Patient in chronic renal failure

**and**

- ○ Haemoglobin is less than or equal to 100g/L

**and**

- ○ Patient does not have diabetes mellitus

  **and**

  ○ 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/min

**or**

- ○ Patient is on haemodialysis or peritoneal dialysis

**INITIATION – myelodysplasia***

Re-assessment required after 2 months

**Prerequisites** (tick boxes where appropriate)

- ○ 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

**and**

- ○ The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week

**CONTINUATION – myelodysplasia***

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

- ○ The patient's transfusion requirement continues to be reduced with epoetin treatment

**and**

- ○ Transformation to acute myeloid leukaemia has not occurred

**and**

- ○ 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:

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

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**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

## Epoetin alfa *- continued*

**INITIATION – all other indications**

**Prerequisites** (tick box 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.

**and**

❍ For use in patients where blood transfusion is not a viable treatment alternative

Note: Indications marked with * are unapproved indications



I confirm that the above details are correct:

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