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	PATIENT:				
Name:	Name:				
Ward:	NHI:				
Epoetin beta					
INITIATION – chronic renal failure Prerequisites (tick boxes where appropriate)					
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				
O Patient has diabetes mell and Glomerular filtration rate	itus s less than or equal to 45ml/min				
or Patient is on haemodialysis or p	peritoneal dialysis				
and Patient has very low, low or intermedi syndrome (WPSS) and Other causes of anaemia such as B1 and Patient has a serum epoetin level of and	aemoglobin < 100g/L and is red cell transfusion-dependent ate risk MDS based on the WHO classification-based prognostic scoring system for myelodysplastic 2 and folate deficiency have been excluded 500 IU/L				
O The minimum necessary dose of epo	etin would be used and will not exceed 80,000 iu per week				
CONTINUATION – myelodysplasia* Re-assessment required after 2 months Prerequisites (tick boxes where appropriate)					
The patient's transfusion requirement and Transformation to acute myeloid leuke	continues to be reduced with epoetin treatment				
and	etin 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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PRES	CRIBER		PATIENT:	
Name	e:		Name:	
Ward	:		NHI:	
Еро	etin beta	a - continued		
		all other indications		
Prer	equisites	(tick boxes where appropriate)		
	O	Haematologist		
	_	O For use in patients where blood transfusion is not a viable treatment alternative		
	and	*Note: Indications marked with * are unapproved indications		

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Signed.	Date:	
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