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)	
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
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) Prescribed by, or recommended by an otolaryngologist, or in accord Hospital. Maximum of 6 doses and The treatment is for intra-lesional administration	ance with a protocol or guideline that has been endorsed by the Health NZ
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 or	
O Exudative ocular angiopathy	

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Signed.	Date:	
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