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: .....

Fulvestrant

INITIATION
Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ○ Patient has oestrogen-receptor positive locally advanced or metastatic breast cancer

and

- ○ Patient has disease progression following prior treatment with an aromatase inhibitor or tamoxifen for their locally advanced or metastatic disease

and

- ○ Treatment to be given at a dose of 500 mg monthly following loading doses

and

- ○ Treatment to be discontinued at disease progression

CONTINUATION
Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ○ Treatment remains appropriate and patient is benefitting from treatment

and

- ○ Treatment to be given at a dose of 500 mg monthly

and

- ○ No evidence of disease progression

I confirm that the above details are correct:

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