RS1827 - Pegylated interferon alfa-2a

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: .....

Pegylated interferon alfa-2a

INITIATION – Chronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV or genotype 2 or 3 post liver transplant
Re-assessment required after 48 weeks
Prerequisites (tick boxes where appropriate)

- ○ Patient has chronic hepatitis C, genotype 1, 4, 5 or 6 infection

or

- ○ Patient has chronic hepatitis C and is co-infected with HIV

or

- ○ Patient has chronic hepatitis C genotype 2 or 3 and has received a liver transplant

Note: Consider 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 treatment since this is predictive of treatment failure.
Consider reducing treatment to 24 weeks if serum HCV RNA level at Week 4 is undetectable by sensitive PCR assay (less than 50IU/ml) AND Baseline serum HCV RNA is less than 400,000IU/ml.

CONTINUATION – Chronic hepatitis C - genotype 1 infection
Re-assessment required after 48 weeks
Prerequisites (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a gastroenterologist, infectious disease specialist or general physician, or in accordance with a protocol or guideline 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

and

- ○ Patient has responder relapsed

or

- ○ Patient was a partial responder

and

- ○ Patient is to be treated in combination with boceprevir

INITIATION – Chronic Hepatitis C - genotype 1 infection treatment more than 4 years prior
Re-assessment required after 48 weeks
Prerequisites (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a gastroenterologist, infectious disease specialist or general physician, or in accordance with a protocol or guideline 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

and

- ○ Patient has responder relapsed

or

- ○ Patient was a partial responder

or

- ○ 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: .....

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PRESCRIBER

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Pegylated interferon alfa-2a *- continued*

INITIATION – Chronic hepatitis C - genotype 2 or 3 infection without co-infection with HIV
Re-assessment required after 6 months
Prerequisites (tick box where appropriate)

- ○ Patient has chronic hepatitis C, genotype 2 or 3 infection

INITIATION – Hepatitis B
Re-assessment required after 48 weeks
Prerequisites (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a gastroenterologist, infectious disease specialist or general physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ○ Patient has confirmed Hepatitis B infection (HBsAg positive for more than 6 months)

and

- ○ Patient is Hepatitis B treatment-naive

and

- ○ ALT > 2 times Upper Limit of Normal

and

- ○ HBV DNA < 10 log10 IU/ml

and

- ○ HBeAg positive

or

- ○ Serum HBV DNA greater than or equal to 2,000 units/ml and significant fibrosis (greater than or equal to Metavir Stage F2 or moderate fibrosis)

and

- ○ Compensated liver disease

and

- ○ No continuing alcohol abuse or intravenous drug use

and

- ○ Not co-infected with HCV, HIV or HDV

and

- ○ Neither ALT nor AST > 10 times upper limit of normal

and

- ○ No history of hypersensitivity or contraindications to pegylated interferon

INITIATION – myeloproliferative disorder or cutaneous T cell lymphoma
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

- ○ Patient has a cutaneous T cell lymphoma*

or

- ○ Patient has a myeloproliferative disorder*

and

- ○ Patient is intolerant of hydroxyurea

and

- ○ Treatment with anagrelide and busulfan is not clinically appropriate

or

- ○ Patient has a myeloproliferative disorder

and

- ○ Patient is pregnant, planning pregnancy or lactating

I confirm that the above details are correct:

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

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PRESCRIBER

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Pegylated interferon alfa-2a *- continued*

CONTINUATION – myeloproliferative disorder or cutaneous T cell lymphoma
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 treatment

and

- ○ Patient has a cutaneous T cell lymphoma*

or

- ○ Patient has a myeloproliferative disorder*

and

- ○ Remains intolerant of hydroxyurea and treatment with anagrelide and busulfan remains clinically inappropriate

or

- ○ Patient is pregnant, planning pregnancy or lactating

Note: Indications marked with * are unapproved indications

INITIATION – 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

- ○ Patient has ocular surface squamous neoplasia*

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)

- ○ 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: .....