

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: .....

**Rosuvastatin**

**INITIATION – cardiovascular disease risk**

**Prerequisites** (tick boxes where appropriate)

- ☐ Patient is considered to be at risk of cardiovascular disease  
**and**  
☐ Patient is Māori or any Pacific ethnicity

**or**

- ☐ Patient has a calculated risk of cardiovascular disease of at least 15% over 5 years  
**and**  
☐ LDL cholesterol has not reduced to less than 1.8 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or simvastatin

**INITIATION – familial hypercholesterolemia**

**Prerequisites** (tick boxes where appropriate)

- ☐ Patient has familial hypercholesterolemia (defined as a Dutch Lipid Criteria score greater than or equal to 6)  
**and**  
☐ LDL cholesterol has not reduced to less than 1.8 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or simvastatin

**INITIATION – established cardiovascular disease**

**Prerequisites** (tick boxes where appropriate)

- ☐ Patient has proven coronary artery disease (CAD)  
**or**  
☐ Patient has proven peripheral artery disease (PAD)  
**or**  
☐ Patient has experienced an ischaemic stroke

**and**

- ☐ LDL cholesterol has not reduced to less than 1.4 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or simvastatin

**INITIATION – recurrent major cardiovascular events**

**Prerequisites** (tick boxes where appropriate)

- ☐ Patient has experienced a recurrent major cardiovascular event (defined as myocardial infarction, ischaemic stroke, coronary revascularisation, hospitalisation for unstable angina) in the last 2 years  
**and**  
☐ LDL cholesterol has not reduced to less than 1.0 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or simvastatin

I confirm that the above details are correct:

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