

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: .....

**Abiraterone acetate**

**INITIATION**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

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

and

- ☐ Patient has prostate cancer

and

- ☐ Patient has metastases

and

- ☐ Patient's disease is castration resistant

and

- ☐ Patient is symptomatic

and

- ☐ Patient has disease progression (rising serum PSA) after second line anti-androgen therapy

and

- ☐ Patient has ECOG performance score of 0-1

and

- ☐ Patient has not had prior treatment with taxane chemotherapy

or

- ☐ Patient's disease has progressed following prior chemotherapy containing a taxane

and

- ☐ Patient has ECOG performance score of 0-2

and

- ☐ Patient has not had prior treatment with abiraterone

**CONTINUATION**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

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

and

- ☐ Significant decrease in serum PSA from baseline

and

- ☐ No evidence of clinical disease progression

and

- ☐ No initiation of taxane chemotherapy with abiraterone

and

- ☐ The treatment remains appropriate and the patient is benefiting from treatment

I confirm that the above details are correct:

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

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**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

**Abiraterone acetate** - continued

**CONTINUATION – pandemic circumstances**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

- ☐ The patient is clinically benefiting from treatment and continued treatment remains appropriate  
**and** ☐ Abiraterone acetate to be discontinued at progression  
**and** ☐ No initiation of taxane chemotherapy with abiraterone  
**and** ☐ The regular renewal requirements cannot be met due to COVID-19 constraints on the health sector

I confirm that the above details are correct:

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