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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.

PATIENT:
Name:
NHI:
AH monotherapy required after 6 months ick boxes where appropriate)
ibed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of iratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ al.
Patient has pulmonary arterial hypertension (PAH)*  PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications
PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV  PAH has been confirmed by right heart catheterisation  and  A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)  and
A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg  Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm <sup>-5</sup> )  PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †  Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**  Patient has PAH other than idiopathic / heritable or drug-associated type
Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease  Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures
O Bosentan is to be used as PAH monotherapy  O Patient has experienced intolerable side effects on sildenafil or O Patient has an absolute contraindication to sildenafil or O Patient is a child with idiopathic PAH or PAH secondary to congenital heart disease

I confirm that the above details are correct: Signed: ...... Date: .....

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

July 2025

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.

ESCRIBER	PATIENT:
me:	
rd:	NHI:
sentan - con	tinued
e-assessment re erequisites (tion Prescrib	H dual therapy equired after 6 months ck boxes where appropriate)  bed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of atory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ I.
and PA	atient has pulmonary arterial hypertension (PAH)*  AH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications  AH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
and	PAH has been confirmed by right heart catheterisation  A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)  A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg  Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm <sup>-5</sup> )  PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †  Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**  Patient has PAH other than idiopathic / heritable or drug-associated type
or or	Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease  Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures
and	D Bosentan is to be used as part of PAH dual therapy  Patient has tried a PAH monotherapy (sildenafil) for at least three months and has experienced an inadequate therapeutic response to treatment according to a validated risk stratification tool**  Patient is presenting in NYHA/WHO functional class III or IV, and in the opinion of the treating clinician would likely benefit from initial dual therapy

I confirm that the above details are correct:	
Signed:	Date:

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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CRIBER	PATIENT:
	Name:
	NHI:
ntan - continued	
a respiratory specialist, cardiologist or Hospital.  Patient has pulmonary arterial hy and	
and	WHO (Venice 2003) clinical classifications siation/World Health Organization (NYHA/WHO) functional class II, III or IV
and A mean pulmonary a and A pulmonary capillar and Pulmonary vascular and PAH has been defined in the or Patient has no risk stratification Patient has PA	artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)  ry wedge pressure (PCWP) less than or equal to 15 mmHg  resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm <sup>-5</sup> )  and demonstrated to be non-responsive in vasoreactivity assessment using illoprost or nitric oxide, as 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines) †  of experienced an acceptable response to calcium antagonist treatment, according to a validated on tool**  AH other than idiopathic / heritable or drug-associated type
and  Description  Patient has palliated single Fontan circulation requiring and  Bosentan is to be used as and  Patient is on the lung or Patient is presenting or Patient has tried	
and	not have major life-threatening comorbidities and triple therapy is not being used in a palliative

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PRESCR	IBER	PATIENT:			
Name:		Name:			
Ward:		NHI:			
bosentan - continued					
	IUATION ssment required after 2 years iisites (tick box where appropriate)				
and	Prescribed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Patient is continuing to derive benefit from bosentan treatment according to a validated PAH risk stratification tool**				

Note: † The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the

diagnosis and treatment of pulmonary hypertension PAH

\*\* the requirement to use a validated risk stratification tool to determine insufficient response applies to adults.

Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

I confirm that the above details are correct: Signed: ...... Date: .....