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				PATIENT:			
Name	e:			Name:			
Ward	:			NHI:			
Emic	Emicizumab						
	ATION – Severe Haemophilia A with or without FVIII inhibitors equisites (tick boxes where appropriate) Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.						
and		Э		eding phenotype (endogenous factor VIII activity less than or equal to			
	and		Emicizumab is to be administered at a dose of no greater than weekly	3 mg/kg weekly for 4 weeks followed by the equivalent of 1.5 mg/kg			

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