

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: .....

**Siltuximab**

**INITIATION**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

- ☐ Prescribed by, or recommended by a haematologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ☐ Patient has severe HHV-8 negative idiopathic multicentric Castleman's Disease
- and
- ☐ Treatment with an adequate trial of corticosteroids has proven ineffective
- and
- ☐ Siltuximab is to be administered at doses no greater than 11 mg/kg every 3 weeks

**CONTINUATION**

Re-assessment required after 12 months

**Prerequisites** (tick box where appropriate)

- ☐ Prescribed by, or recommended by a haematologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ☐ The treatment remains appropriate and the patient has sustained improvement in inflammatory markers and functional status

I confirm that the above details are correct:

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