HOSPITAL MEDICINES LIST
RESTRICTIONS CHECKLIST

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: .....

Bevacizumab

INITIATION – Recurrent Respiratory Papillomatosis
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

- ○ Prescribed by, or recommended by an otolaryngologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ○ Maximum of 6 doses

and

- ○ The patient has recurrent respiratory papillomatosis

and

- ○ The treatment is for intra-lesional administration

CONTINUATION – Recurrent Respiratory Papillomatosis
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

- ○ Prescribed by, or recommended by an otolaryngologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ○ Maximum of 6 doses

and

- ○ The treatment is for intra-lesional administration

and

- ○ There has been a reduction in surgical treatments or disease regrowth as a result of treatment

INITIATION – ocular conditions
Prerequisites (tick boxes where appropriate)

- ○ Ocular neovascularisation

or

- ○ Exudative ocular angiopathy

I confirm that the above details are correct:

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