

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: .....

**Aflibercept**

**INITIATION – Wet Age Related Macular Degeneration**

Re-assessment required after 3 months

**Prerequisites** (tick boxes where appropriate)

- ☐ Prescribed by, or recommended by an ophthalmologist or nurse practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ☐ Wet age-related macular degeneration (wet AMD)  
or  
☐ Polypoidal choroidal vasculopathy  
or  
☐ Choroidal neovascular membrane from causes other than wet AMD

and

- ☐ The patient has developed severe endophthalmitis or severe posterior uveitis following treatment with bevacizumab  
or  
☐ There is worsening of vision or failure of retina to dry despite three intraocular injections of bevacizumab four weeks apart

and

- ☐ There is no structural damage to the central fovea of the treated eye  
and  
☐ Patient has not previously been treated with ranibizumab for longer than 3 months

or

- ☐ Patient has current approval to use ranibizumab for treatment of wAMD and was found to be intolerant to ranibizumab within 3 months  
or  
☐ Patient has previously\* (\*before June 2018) received treatment with ranibizumab for wAMD and disease was stable while on treatment

**CONTINUATION – Wet Age Related Macular Degeneration**

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

- ☐ Prescribed by, or recommended by an ophthalmologist or nurse practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ☐ Documented benefit must be demonstrated to continue  
and  
☐ Patient's vision is 6/36 or better on the Snellen visual acuity score  
and  
☐ There is no structural damage to the central fovea of the treated eye

I confirm that the above details are correct:

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

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**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

**Aflibercept - continued**

**INITIATION – Diabetic Macular Oedema**

Re-assessment required after 4 months

**Prerequisites** (tick boxes where appropriate)

- ☐ Prescribed by, or recommended by an ophthalmologist or nurse practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ☐ Patient has centre involving diabetic macular oedema (DMO)
- and
- ☐ Patient's disease is non responsive to 4 doses of intravitreal bevacizumab when administered 4-6 weekly
- and
- ☐ Patient has reduced visual acuity between 6/9 – 6/36 with functional awareness of reduction in vision
- and
- ☐ Patient has DMO within central OCT (ocular coherence tomography) subfield > 350 micrometers
- and
- ☐ There is no centre-involving sub-retinal fibrosis or foveal atrophy

**CONTINUATION – Diabetic Macular Oedema**

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

- ☐ Prescribed by, or recommended by an ophthalmologist or nurse practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ☐ There is stability or two lines of Snellen visual acuity gain
- and
- ☐ There is structural improvement on OCT scan (with reduction in intra-retinal cysts, central retinal thickness, and sub-retinal fluid)
- and
- ☐ Patient's vision is 6/36 or better on the Snellen visual acuity score
- and
- ☐ There is no centre-involving sub-retinal fibrosis or foveal atrophy
- and
- ☐ After each consecutive 12 months treatment with aflibercept, patient has retrialled with at least one injection of bevacizumab and had no response

I confirm that the above details are correct:

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