

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: .....

**Iloprost**

**INITIATION – PAH monotherapy**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

- ☐ 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.

and

- ☐ Patient has pulmonary arterial hypertension (PAH)

and

- ☐ PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications

and

- ☐ PAH 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

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

and

- ☐ A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm<sup>-5</sup>)

and

- ☐ 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) †

or

- ☐ Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool\*\*

or

- ☐ Patient has PAH other than idiopathic / heritable or drug-associated type

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

or

- ☐ 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

- ☐ Iloprost is to be used as PAH monotherapy

and

- ☐ Patient has experienced intolerable side effects on sildenafil and both the funded endothelin receptor antagonists (i.e. both bosentan and ambrisentan)

or

- ☐ Patient has an absolute contraindication to sildenafil and an absolute or relative contraindication to endothelin receptor antagonists

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**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

**Iloprost - continued**

**INITIATION – PAH dual therapy**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

- ☐ 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.

and

- ☐ Patient has pulmonary arterial hypertension (PAH)

and

- ☐ PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications

and

- ☐ PAH 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

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

and

- ☐ A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm<sup>-5</sup>)

and

- ☐ 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) †

or

- ☐ Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool\*\*

or

- ☐ Patient has PAH other than idiopathic / heritable or drug-associated type

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

or

- ☐ 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

- ☐ Iloprost is to be used as PAH dual therapy with either sildenafil or an endothelin receptor antagonist

and

- ☐ Patient has an absolute contraindication to or has experienced intolerable side effects on sildenafil

or

- ☐ Patient has an absolute or relative contraindication to or experienced intolerable side effects with a funded endothelin receptor antagonist

and

- ☐ Patient has tried a PAH monotherapy for at least three months and remains in an unacceptable risk category according to a validated risk stratification tool\*\*

or

- ☐ Patient is presenting in NYHA/WHO functional class III or IV, and in the opinion of the treating clinician would benefit from initial dual therapy

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**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

**Iloprost - continued**

**INITIATION – PAH triple therapy**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

- ☐ 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.

and

- ☐ Patient has pulmonary arterial hypertension (PAH)

and

- ☐ PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications

and

- ☐ PAH 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

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

and

- ☐ A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm<sup>-5</sup>)

and

- ☐ 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) †

or

- ☐ Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool\*\*

or

- ☐ Patient has PAH other than idiopathic / heritable or drug-associated type

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

or

- ☐ 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

- ☐ Iloprost is to be used as PAH triple therapy

and

- ☐ Patient is on the lung transplant list

or

- ☐ Patient is presenting in NYHA/WHO functional class IV

or

- ☐ Patient has tried PAH dual therapy for at least three months and has not experienced an acceptable response to treatment according to a validated risk stratification tool\*\*

and

- ☐ Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario

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**PRESCRIBER**

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Ward: .....

**PATIENT:**

Name: .....

NHI: .....

**Iloprost** - continued

**CONTINUATION**

Re-assessment required after 2 years

**Prerequisites** (tick box where appropriate)

☐ 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.

and

☐ Patient is continuing to derive benefit from iloprost 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.

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