

## RS1827 - Pegylated interferon alfa-2a

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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: .....

**Pegylated interferon alfa-2a**

**INITIATION – Chronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV or genotype 2 or 3 post liver transplant**

Re-assessment required after 48 weeks

**Prerequisites** (tick boxes where appropriate)

- ☐ Patient has chronic hepatitis C, genotype 1, 4, 5 or 6 infection  
or  
☐ Patient has chronic hepatitis C and is co-infected with HIV  
or  
☐ Patient has chronic hepatitis C genotype 2 or 3 and has received a liver transplant

Note: Consider stopping treatment if there is absence of a virological response (defined as at least a 2-log reduction in viral load) following 12 weeks of treatment since this is predictive of treatment failure.

Consider reducing treatment to 24 weeks if serum HCV RNA level at Week 4 is undetectable by sensitive PCR assay (less than 50IU/ml) AND Baseline serum HCV RNA is less than 400,000IU/ml.

**CONTINUATION – Chronic hepatitis C - genotype 1 infection**

Re-assessment required after 48 weeks

**Prerequisites** (tick boxes where appropriate)

- ☐ Prescribed by, or recommended by a gastroenterologist, infectious disease specialist or general physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  
and  
☐ Patient has chronic hepatitis C, genotype 1  
and  
☐ Patient has had previous treatment with pegylated interferon and ribavirin  
and  
☐ Patient has responder relapsed  
or  
☐ Patient was a partial responder  
and  
☐ Patient is to be treated in combination with boceprevir

**INITIATION – Chronic Hepatitis C - genotype 1 infection treatment more than 4 years prior**

Re-assessment required after 48 weeks

**Prerequisites** (tick boxes where appropriate)

- ☐ Prescribed by, or recommended by a gastroenterologist, infectious disease specialist or general physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  
and  
☐ Patient has chronic hepatitis C, genotype 1  
and  
☐ Patient has had previous treatment with pegylated interferon and ribavirin  
and  
☐ Patient has responder relapsed  
or  
☐ Patient was a partial responder  
or  
☐ Patient received interferon treatment prior to 2004  
and  
☐ Patient is to be treated in combination with boceprevir

I confirm that the above details are correct:

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

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**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

**Pegylated interferon alfa-2a - continued**

**INITIATION – Chronic hepatitis C - genotype 2 or 3 infection without co-infection with HIV**

Re-assessment required after 6 months

**Prerequisites** (tick box where appropriate)

- ☐ Patient has chronic hepatitis C, genotype 2 or 3 infection

**INITIATION – Hepatitis B**

Re-assessment required after 48 weeks

**Prerequisites** (tick boxes where appropriate)

- ☐ Prescribed by, or recommended by a gastroenterologist, infectious disease specialist or general physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ☐ Patient has confirmed Hepatitis B infection (HBsAg positive for more than 6 months)

and

- ☐ Patient is Hepatitis B treatment-naïve

and

- ☐ ALT > 2 times Upper Limit of Normal

and

- ☐ HBV DNA < 10 log<sub>10</sub> IU/ml

and

- ☐ HBeAg positive

or

- ☐ Serum HBV DNA greater than or equal to 2,000 units/ml and significant fibrosis (greater than or equal to Metavir Stage F2 or moderate fibrosis)

and

- ☐ Compensated liver disease

and

- ☐ No continuing alcohol abuse or intravenous drug use

and

- ☐ Not co-infected with HCV, HIV or HDV

and

- ☐ Neither ALT nor AST > 10 times upper limit of normal

and

- ☐ No history of hypersensitivity or contraindications to pegylated interferon

**INITIATION – myeloproliferative disorder or cutaneous T cell lymphoma**

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

- ☐ Patient has a cutaneous T cell lymphoma\*

or

- ☐ Patient has a myeloproliferative disorder\*

and

- ☐ Patient is intolerant of hydroxyurea

and

- ☐ Treatment with anagrelide and busulfan is not clinically appropriate

or

- ☐ Patient has a myeloproliferative disorder

and

- ☐ Patient is pregnant, planning pregnancy or lactating

I confirm that the above details are correct:

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

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: .....

**Pegylated interferon alfa-2a - continued**

**CONTINUATION – myeloproliferative disorder or cutaneous T cell lymphoma**

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

- ☐ No evidence of disease progression  
and  
☐ The treatment remains appropriate and patient is benefitting from treatment  
and  
☐ Patient has a cutaneous T cell lymphoma\*  
or  
☐ Patient has a myeloproliferative disorder\*  
and  
☐ Remains intolerant of hydroxyurea and treatment with anagrelide and busulfan remains clinically inappropriate  
or  
☐ Patient is pregnant, planning pregnancy or lactating

Note: Indications marked with \* are unapproved indications

**INITIATION – ocular surface squamous neoplasia**

Re-assessment required after 12 months

**Prerequisites** (tick box where appropriate)

- ☐ Prescribed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  
and  
☐ Patient has ocular surface squamous neoplasia\*

**CONTINUATION – ocular surface squamous neoplasia**

Re-assessment required after 12 months

**Prerequisites** (tick box where appropriate)

- ☐ Prescribed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  
and  
☐ The treatment remains appropriate and patient is benefitting from treatment

Note: Indications marked with \* are unapproved indications

**INITIATION – post-allogenic bone marrow transplant**

Re-assessment required after 3 months

**Prerequisites** (tick box where appropriate)

- ☐ Patient has received an allogeneic bone marrow transplant\* and has evidence of disease relapse

**CONTINUATION – post-allogenic bone marrow transplant**

Re-assessment required after 3 months

**Prerequisites** (tick box where appropriate)

- ☐ Patient is responding and ongoing treatment remains appropriate

Note: Indications marked with \* are unapproved indications

I confirm that the above details are correct:

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