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: .....

Ranibizumab

INITIATION – Wet Age Related Macular Degeneration
Re-assessment required after 3 months
Prerequisites (tick boxes where appropriate)

- ○ 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 aflibercept or faricimab for longer than 3 months

or

- ○ Patient has current approval to use aflibercept or faricimab for treatment of wAMD and was found to be intolerant within 3 months

CONTINUATION – Wet Age Related Macular Degeneration
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

- ○ 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: .....